BEFORE THE UNITED STATES
NUCLEAR REGULATORY COMMISSION

IN RE: THE MATTER)
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OF)
)
DAVIS-BESSE)

REPORT OF PROCEEDINGS
October 1, 2003
12:30 P.M.

REPORT OF PROCEEDINGS had and testimony taken the hearing of the above-entitled matter, held before Mr. Jack Grobe, at the Nuclear Regulatory Commission, 801 Warrenville Road, Lisle, Illinois.

PRESENT ON BEHALF OF N.R.C.:

MR. JACK GROBE, Hearing Officer;

MR. JAMES CALDWELL;

MR. SCOTT THOMAS;

MS. CINDY PEDERSON;

MS. CHRISTINE LIPA;

MR. GEOFF GRANT;

MR. GEOFF WRIGHT;

MR. MONTE PHILLIPS; and
MR. DAVID PASSEHL.
PRESENT ON BEHALF OF DAVIS-BESSE:
MR. LEW MYERS;
MR. GARY LEIDICH;
MR. DAVE GUDGER;
MR. JOE HAGAN;
MR. RANDY FAST;
MR. FRED VON AHN;
MR. MARK BEZILLA;
MR. ART LEWIS;
MR. RAY ZUICHOWICZ; and
MR. JACK RUETER.
PRESENT At HEADQUARTERS;
MR. JON HOPKINS;
MR. BILL RULAND;
MS. LISA JARRIEL;
MS. CLAIRE GOODMAN;
MR. JULIUS PERSENSKY;
MR. TONY MENDIOLA; and
MR. STEVE BLOOM.

MR. GROBE: Good afternoon. My name is Jack Grobe. I'd like to welcome First Energy and N.R.C. participants and members of the public at the various locations to this meeting. I'm the Senior Manager here in the Region III office of the Nuclear Regulatory Commission, and also Chairman of the N.R.C. Oversight Panel for the Davis-Besse facility.

The N.R.C. is meeting today with First Energy to understand the progress that they have made in restoring a healthy safety culture in the organization at Davis-Besse and discuss First Energy's plans for continuing improvement and monitoring of the organization's safety focus.

The N.R.C. goal today is to obtain information from First Energy. We will not be providing an assessment or conclusion regarding the information we hear today. I expect that there will be many questions from members of the N.R.C. staff regarding the information First Energy presents. Questions should not be

construed as positions or conclusions by the N.R.C. We have ongoing safety inspections. When the inspection team finishes its activities, we will discuss its conclusions during the public meetings.

This meeting between the N.R.C. and First Energy is open to public observation here in the N.R.C. Region III office in Lisle, Illinois, and through video conferencing in the N.R.C. headquarters offices in Rockville, Maryland. Also, members of the public can listen to the meeting through a toll free audio teleconference bridge.

After the N.R.C. discussions today with First Energy are completed, there will be opportunities for members of the public here and at Rockville, Maryland, and on the telephone conference bridge to ask questions of the N.R.C. staff or make comments.

We are also having this meeting transcribed today to maintain a record of the meeting. The transcript will be available on the

N.R.C. web page several weeks after today's meeting.

Copies of the First Energy presentation slides are available in the back of this conference room and in N.R.C. headquarters, and also available on the N.R.C. web site at www.nrc.gov, then select under key topics Davis-Besse, select public meetings on the menu, and then select October 1, 2003.

Also, in our conference rooms are N.R.C. meeting feedback forms that you can fill out and provide feedback on the format and content or any other aspect of these meeting, so that we can improve the quality of our public meetings.

Our web site has a Davis-Besse link that contains a wealth of other documents regarding activities that are ongoing at Davis-Besse, including the N.R.C. routine monthly public newsletters.

At this time I'd like to introduce the N.R.C. staff that are here in Chicago today,

and also ask headquarters N.R.C. staff to introduce themselves, and then have First Energy introduce their staff at the table.

On my immediate left is Christine Lipa. Christine is Branch Chief responsible for Davis-Besse oversight in Region III. Next to her in Cindy Pederson, Director of Reactor Safety for the reactors in Region III. On my immediate right is Jim Caldwell, Jim is the Regional Administrator in this regional office. On his right is Geoff Grant, our Deputy Regional Administrator, and then Geoff Wright, the team leader of the Safety Culture Inspection Team. Also at the table is Monte Phillips, who is a Senior Project Engineer working on the Davis-Besse project.

Could I ask the headquarters N.R.C. staff to introduce themselves at this time.

MR. HOPKINS: Yes. This is Jon Hopkins, project manager for Davis-Besse at N.R.R.

MR. MENDIOLA: tony Mendiola with N.R.R.

for reactor projects.

MR. RULAND: Bill Ruland, Project Director.

MR. PERSENSKY: J. Persensky, I'm part of the Inspection Team for Safety Culture in the Office of Research here at N.R.C. headquarters.

MS. JARRIEL: Lisa Jarriel, I'm also part of the inspection team on safety culture and I'm the agency allegations advisor.

MS. GOODMAN: I'm Claire Goodman, and I'm also on the Safety Culture Inspection Team, I'm from the office of N.R.R.

MR. BLOOM: I'm Steve Bloom, I'm the Project Manager assisting on Davis-Besse issues.

MR. HOPKINS: That's it for N.R.C. folks here in Region III. We do have one member of the media here also.

MR. GROBE: Thanks, Jon.

Gary, could you introduce your people?

MR. LEIDICH: Thank you, Jack, good afternoon.

On my far left is Mark Bazilla, Site

Vice-President; to my immediate left is Lew Myers, Chief Operating Officer for First Energy Nuclear Operating Company. To my immediate right is Fred von Ahn, Vice-President of Oversight for First Energy Nuclear Operating Company, and on his right is Randy Fast, Director of Organizational Effectiveness, who will talk more about his assignment during our presentation.

To his right is a new employee, Joe Hagan, Senior Vice-President. We are excited to have Joe on board, he brings to us a wealth of experience from Exelon Energy, and he wanted me to say Pico, so I did. To his right is Dave Gudger, Supervisor of Regulatory Affairs. I have a couple of additional employees, and I will just ask them to introduce themselves.

MR. ZUICHOWICZ: Ray Zuichowicz.

MR. RUETER: Jack Rueter, I work at radiation protection.

MR. LEWIS: Art Lewis.

MR. LEIDICH: The reason for these employees attending is just to provide

opportunities for you to ask any questions of them. They have been integral to our change process from a safety culture perspective, so we welcome the opportunity to have that exchange.

We do, as you noted, Jack, have a lot of material, but we will try to run through it fairly briefly right up front.

MR. GROBE: Thanks, Gary. I have a couple opening remarks that I'd like to make. Just one reminder, since we have folks on a teleconference bridge, as well as the video teleconferencing, it's very important to use the microphones, so make sure your little LED is bright green, and make sure you speak into the microphone when you speak. Thank you.

In February of 2002, the Davis-Besse facility was shut down for refueling and inspection of the reactor pressure vessel head penetrations pursuant to N.R.C. bulletin 2001-01. In March, 2002, during repairs of cracks, First Energy discovered this reactor head penetration. First Energy identified significant

corrosion and degradation of the reactor head adjacent to a cracked penetration.

Since that time First Energy has been implementing actions to identify and address the causes of the reactor head degradation. In August of 2002, First Energy reported to the N.R.C. in a public meeting that a significant contributor to the head degrading was inadequate nuclear safety focus at the Davis-Besse organization. The focus at that time had been on production and minimum actions to meet safety requirements that resulted in an unacceptable tolerance of degraded safety margins.

In the fall of 2002, First Energy evaluated the safety conscious work environment with a willingness of the organization to identify and address safety concerns. The results of the evaluation showed many challenges in that area.

A follow-up evaluation was conducted in the spring of 2003. N.R.C. staff reviewed First Energy root cause assessments and

agreed that safety culture was a significant contributor to the reactor head degradation.

However, N.R.C. staff also concluded that First Energy had not fully evaluated the ramifications of this cultural problem throughout the organization. Following this, First Energy expanded their evaluation, looked at multiple elements of the organization, including operations, engineering, quality assurance, corporate support and independent oversight.

Those broader assessments were found to be sufficient in breadth and depth. Also, in the spring of 2003, First Energy contracted for an independent assessment of organizational safety culture conducted under the direction of Dr. Soney Abram. That assessment found that many of the elements necessary for effective safety focus at Davis-Besse were in place. However, there was inconsistencies in the stated goals and expectations within the organization and a lack of effective

communication and alignment on safety priority across the various departments and vertically within the organization.

First Energy has been developing and implementing improvement actions to address safety culture at Davis-Besse. Progress in this area has been a topic discussed at multiple public meetings in the past. Our goal today is to occasionally understand where First Energy is in implementation of the organization's human performance and safety culture improvement plans and what actions First Energy is considering going forward.

Again, I expect the N.R.C. staff will have a number of questions to clarify the information that you present today. Those questions should not be construed as positions or conclusions of the N.R.C. I also note that you have some 90 slides in your presentation, I would hope that the N.R.C. staff will hold questions until the end of each topic area to allow you to efficiently present your material.

At this time, Gary, I'd like to turn the meeting over to you and First Energy for your presentation.

MR. LEIDICH: Thank you very much, Jack, and once again good afternoon everyone. The agenda is presented on Page 3. I won't dwell on that, I will go right to desired outcomes on Slide 4.

MR. GROBE: Gary, excuse me, Scott Thomas just arrived, he is the senior resident inspector at the Davis-Besse plant. He was delayed this morning because of an operational problem last night at the plant. He had to report to the plant very early this morning, and then drove to the region, so he was a few minutes late. I apologize, but he's here now.

MR. LEIDICH: Thank you. And once again the desired outcomes today are to demonstrate that we are building an organization with proactive safety culture that is really built to last. We recognize that the actions underway and the actions that we need to complete from a

corporate perspective, not only Davis-Besse, but really fleet wide, need to be fully comprehensive and very long lasting.

We also today would like to provide an understanding, holistic understanding if you will of the key elements of our safety culture model process results, the actions we have taken to date, our view of the effectiveness of those actions and longer term plans and outlooks.

Slide 5, as reiterated before, we do indeed have a corporate commitment from the top of the shop down through the organization, including actual written commitments from the CEO, and also a board resolution from the First Energy board and a policy on safety culture and commitment to that policy.

At that time last fall we did develop the three portions of safety culture that we will present today, corporate commitment, the management commitment an individual commitments.

Just a comment on the concept of

"built to last." We recognize the importance of improving performance really in all aspects of Davis-Besse, but particularly safety culture. And the real challenge that we have, that anyone has in a process like this is to build an enduring organization, that is really fundamental, and consistently aligned at all levels to the core values of the safe and reliable operation of Davis-Besse.

So as you can see here on Slide 6, what we have been all about and what we will continue to be about is to continuously indoctrinate the employee to these values, nurturing and selecting senior management that fit with these values. And, again, we are delighted to bring Joe Hagan on, and as you are aware, we are recruiting other individuals as well.

Consistent alignment with these core values and goal-setting, problem-solving, decision-making, and preserving those values and a strong resolve for safety focus.

From an organizational standpoint, over the past year or so you can talk about transition of our organization. On Slide 7 is our previous organization. Really, we were three individual facilities with one president and CNO. On Slide 8, you heard these before, that kind of an organizational structure can lead to some pitfalls and some issues, and we believe some of those contributed to the situation at Davis-Besse.

Certainly, the idea of isolationism and difference in management processes across all three stations, corrective actions program weakness at Davis-Besse, cultural variations, resistance of the facility to industry standards, and really the independence of oversight are all areas that that previous organization really facilitated happening, if you will.

So we have taken that to heart, and Slide 9 is a display of our current organization. And as can you see, it's

substantially strengthened in a couple of aspects. First of all, top of the shop, in terms of executive leadership, but also in terms of a corporate office. And as Joe Hagan fills the job of senior vice-president and engineering support, he will have the primary responsibility involved in those standards across the fleet.

The advantages to today's organization as we see it to is develop those common processes based on industry best practice, and our executive team, including Lew and myself, my experience, we believe we have seen what those practices look like, and we were in the process of beginning to put those in place, particularly at Davis-Besse, really fleet wide, that creates for us a strong governance from a First Energy perspective. And of course, as we have talked in the past, we now have a completely independent oversight officer who is responsible for oversight and reports on the dotted line to the board of director's nuclear committee.

Lew will have responsibility for

consistent implementation of those common processes, those best practices across all three of our stations, and of course he's had up close and personal operating experience at really all three of our plants, so that that will facilitate him being able to do that, and as I mentioned, Joe will have the responsibility for developing those processes.

So our bottom line is that we have an organization in place today to ensure a strong safety focus and facilitate top fleet performance. About halfway through the presentation as I talk about the long-term plans and where we go from here, we will cover a few of those specifics about what we mean by that.

So in an introductory standpoint, that completes my remarks. And I don't know if you'd like to take any questions now, Jack, or we can do this in pieces, or --

MR. GROBE: I think most of that information had already been shared with us publicly. I'm not sure there are any questions

at this point. Why don't we move on to Lew's presentation.

MR. MYERS: Thank you, Jack, Gary. Today I'd like to talk about six functional areas, if you will. First, the definition of safety culture and how safety culture and safety conscious work environment are related. I'd like to review the model of safety culture, then I'd like to talk about the process that we are using to evaluate our safety culture and make improvements in our safety culture going forward, and ensure that we have the organization built to last in that area.

I will share with you the results of the actions that we have taken based on our assessment to date and effectiveness of those actions, if you will.

Safety culture is an interesting definition. I went back and read last night where the definition came from, and that is simply, "that assembly of characteristics and attitudes in organizations and individuals which

establishes and overriding priority towards nuclear safety activities and ensures that issues receive the attention warranted by their significance."

The definition of safety culture has very important words and actions that are important. The first is the assembly of characteristics and attitudes. If I look that up, that means defining features and quality, the quality of the organization and features we possess. Next, in both the organization and individual people must have a common interest, they must share a common interest. And that has to do with our organization and our individuals. Safety is a word that has to do with nonexposure to risk, nonexposure to risk, understand the safety issues and their exposure to risk and attention to their significance is the appropriate treatment based on importance.

Proper safety culture establishes an environment in which people are encouraged to identify problems and ensures that problems are

effectively corrected without fear of retaliation. So safety conscious work environment is a good part of a good safety culture. You can't have one without the other.

We started out with our safety culture model by looking at the International Atomic Energy Agency Model INSAG-4, which is an independent inter-government science and technology based organization in the United Nations family that serves as a global focal point for nuclear cooperation.

They develop standards, and these standards promote the achievement of maintaining high levels of safety, as well as protection of human health and environment against a high radiation. The basic principles for nuclear plant safety were developed, and the document they prepared is INSAG-13 and then final safety culture is document INSAG-4.

The present commonly used safety culture objectives, concepts and principles that can be used both by international assistance

members when evaluating and improving the safety culture at the plant, INSAG-4 document was brought by Dr. Sonja Haber, who has a strong background in the international family in safety culture.

Dr. Haber is the president of Performance Safety and Health Services. Dr. Haber had been involved with research in the area of human performance and analysis for over 20 years. She conducted research in the evaluation of behavioral data in various applications for the past ten years.

Dr. Haber worked primarily in the nuclear industry with an emphasis on the role of organizational management influence on safety performance. She's been extensively involved in conducting field work for both nuclear regulatory agencies, the U.S. Department of Energy and other organizations overseas.

We brought her and her team in and performed an independent assessment of our safety culture last year -- at the beginning of this

year. The first thing that we did is we took the INSAG report, which was approved in 1991, after the Chernobel accident as an industry-accepted model.

The INSAG report was intended to promote practical actions to all levels to enhance safety and provide a basis for judging the safety culture. That is the basis of that document. The safety culture mold was established with a document as well as methodology for evaluating safety culture. So if you go in the document and read the specific questions and objectives that can be used to evaluate safety culture.

Based on our review of that document, our starting point was that this was a quality methodology. If you look at the document, there is a model that is presented here that talks about policy level commitment. That has to do with the organization commitment, the management level commitment at our plants and finally how that affects the individuals and

their work every day to ensure that safety-related activities receive the attention warranted. We thought that that was a good starting point.

On April 14, 2003, the Performance Safety and Health completed their independent review of our safety culture. They evaluated Davis-Besse Nuclear Power Station, they looked at particular behaviors and attitudes that were evaluated to determine the extent to which the organization had attained safety culture objectives.

In their minds the methodology consists of functional analysis, structured interviews that were prepared, behavior anchored rating scale, which is a model used to look at behavior ratings, behavior checklists and finally surveys.

A new term was introduced at many of our meetings called "convergent validity" that had to do with various methods of evaluating safety culture and looking for common

indications. It's a fancy term, convergent validity, that we have learned to accept at Davis-Besse. We wanted to take the INSAG-4 model and compare it to Dr. Haber's model. Both address the behaviors and the attributes, but to ensure that there was similarity between our process and to ensure that there was convergent validity in various methods, so if you look at the chart that we have here, it's called a relationship diagram, where we took all the behavioral criteria that Dr. Haber has across the top and looked to ensure that our criteria across the left-hand side was in line with that of Dr. Haber's, or are we missing anything. That's what we are trying to do.

Based on that review, we went back and looked at the atomic -- International Atomic Energy Agency guideline for the behaviors and the Dr. Haber report and we added four new criteria to our model, if you will. Cross functional work management and communications was a criteria added at the bottom left. And environment of

engagement and commitment was another area added. Assessment -- self assessment was a final area that we added, and then independent oversight, which we thought was really a stand-alone criteria that wasn't really reviewed in the INSAG-4 model.

Once again, for each one of those criteria under the functional areas, then the individual commitment area, the plant management commitment area and the policy or corporate level commitment area, the specific and manageable criteria that we used to assess our safety culture. The development of our safety culture process has taken many months. We communicated the importance of nuclear safety culture with all of our employees, that is one of the first actions we did is sit down and explain the model before we explained it to the N.R.C. to the employees, we created a safety culture model based on industry experience to date, and that of the International Atomic Energy Agency Performance Safety and Health Associates

performed their independent review in February, and then we conducted -- since then we have conducted two self assessments and internal surveys to evaluate the safety culture at the Davis-Besse plant and develop the business practice that we are using today in each of our meetings prior to changing plant conditions to ensure that safety culture is on a positive trend.

After Performance Safety and Health Association's safety culture assessment, actions were taken to improve the policy level of commitment, management level commitment, individual commitment areas. Management policies were improved, management meetings were improved to focus on safety improvements that were made in the management observation process.

For example, we did not have a management observation process that was computerized like we have now, and we gained a lot out of that process. In individual commitment areas, actual actions were taken to

share this report immediately -- the Dr. Sonja Haber report with our employees to strengthen our turnover process as a result of that review. So we took prompt actions after that review.

The first assessment for Mode 5 indicated all three commitment areas were rated as yellow, needing prompt management attention. Areas for improvement were included.

If you look at this first Mode 5 assessment, all the -- we rated ourselves in all the functional areas, individual commitment areas, plant management commitment area, policy or corporate level commitment area as yellow.

The yellow indicates that either strong compensatory actions need to be taken, or in the long-term, management improvements need to be taken, but the basic safety culture would be rated as acceptable.

Some of the things that drove that evaluation was the FENOC business plan, which needed many improvements at the time. The FENOC business plan that we had at the time, the vision

was not clear, safety was not a clear focus in that plan, and we went back and made many upgrades since then to improve the vision statement and the safety commitment and even the functional areas in our business plant. Also, personnel in the personnel resources and engineering and security were a problem. Those two issues were the main reason that the policy level commitment area was rated as yellow.

Radiation protection, as you know, in our plant was an issue. That was an issue that we had to take on. That specific issue was a major factor in rating the plant's management commitment area yellow.

Organizational work control issues were also a problem in our plant at the time. We were having to rework some problems. Rework was higher than desired, and it still is, and that was a major influence to the yellow aspect of the commitment area.

Then in the individual area, we were having significant problems with rework at

the time, especially in the -- not only in our own class, but some of the contractors we had problems with jobs like our feedwater jobs and also some jobs in our containment. And based on that individual commitment area, we went ahead and looked at the rework area also.

Our next assessment showed significant improvement, and was prior to this Mode 4. The policy level and individual commitment areas were rated as white, which indicates that the areas are acceptable, and yet there is still some areas for improveMent. The management commitment area was rated as yellow because self assessments for the next year have not been scheduled yet, and with all of the self assessment we have done at the plant, all the self assessments we continue to do, we still do not meet the requirement of having next year's self assessment plan in place and approved, so we rated the plant management commitment area as yellow based on that.

Employee development plans were

also not complete and was a major input and management observations that we were performing, and even though we had the numbers up, were not giving us the results that we had hoped for, and we didn't feel that they were as critical as outside organizations that we were bringing in to perform other management assessments of work at our plant.

Those things wound up causing the management commitment area to be yellow once again. Once again, the overall safety culture at our plant we rated as significant between the Mode 5 evaluation and the Mode 4 evaluation.

MR. GROBE: Why don't you leave that Slide 21 up for a minute. I observed some of your meetings that implement safety culture assessment model, and our inspection team, safety culture inspection team have also observed a number of these activities, along with resident staff. I think there is a number of questions that they may have on the way in which you do this internal safety culture assessment. Why don't we pause

for a minute and see if there are any questions.

MR. WRIGHT: Excuse me, this is Geoff Wright. In looking at individual areas, Lew, in the inspection, we also looked at how you put this together against some of the international documents, the pieces below this that feed in here. Now, those are items, though, that you generated on your own as to how to look into these various areas; is that true?

MR. MYERS: Yes and no. We generate -- I would say yes, but we looked at questions that were in the INSAG-4 document, and that helped generate some of the questions. And then we went back and looked for specific measurable criteria that can be used for each one of the objectives. To measure that objective, if you look at our process, I think it's like a 40-page document for -- for example, in the commitment to safety area there would be -- there will be a complete list of questions and criteria that we used to measure that area. That objective --

MR. HOPKINS: We are having some trouble

hearing you, Lew, if you try a different -- it's like you're breaking up.

MR. MYERS: I can hook up --

MR. HOPKINS: It comes in and out. We're not sure what it is.

MR. MYERS: Did that answer your question?

MR. WRIGHT: Yes. The only follow-up I had was in, you know, we have looked at the process for how you start answering the questions and that all rolls up to what we see here?

MR. LEIDICH: That is correct.

MR. WRIGHT: I know some changes have been made in the way that rolls up and where you find yellows and reds, you are taking action or putting out condition reports --

MR. MYERS: Right.

MR. WRIGHT: Could you tell me a little bit about at what level? I know we start with the individual questions will determine, you know, if an organization is yellow or red in a specific area. Is that a CR or the CRs only come once you get up to what we are seeing here on Slide 21?

MR. MYERS: No, we would expect the organization to write a CR, if they have issues to address those issues, but it would not be high level management CR. If one of these commitment areas is red, then that would be a high level CR that would require -- the way our process would work, would require you bring that issue in to the senior team and present the action plan to make corrections. So it would be a more broad-based CR that we are seeing multiple cases of a particular problem, maybe it's staffing. It's a good example when we had two areas in one of our evaluations that we had staffing concerns in security and engineering at the time, so as a senior leadership team we look at that issue with a CR, the action plans had to come to us for approval, and we drove in to staffing that we needed in place.

MR. WRIGHT: Okay. For just the information like you said, you've got about a 40- to 60-page -- about a 40-page document of questions that have to be answered for -- so that

everyone understands, how are the answers to those to pages answered? And you have what, 22 organizations --

MR. MYERS: Right.

MR. WRIGHT: -- that deal with this, and in a metrics method, how does that roll up to here?

MR. MYERS: Let me talk a little bit about our process then. Our process is -- once again, it's got like a 40-page document of questions, I have it here in front of me. Here is -- for each management commitment area, there is a whole list of criteria. We asked each department to go back and assess themselves to that criteria, you know. Now, once they have done that, we hold a meeting, a management meeting with all the managers at the plant, and have the managers present their management criteria to the management team.

And then often changes, like for instance if management comes in, which they did, and they thought their rework was okay and we were not satisfied with that rework, even though before they got through, we wound up getting one

from maybe white to yellow.

And so it takes a consensus of the management level to agree on a grading of a specific criteria, so each group comes in and presents each individual criteria to that management team, we have agreement on top of that, we bring some independent contractors in, and we also have our quality assurance group do their own self assessment of the safety culture of our plant. So they sit in the back and listen, and that way we get convergence, similar to the Haber methodology, and additionally we have some surveys that we use to ensure that we have convergence, 4-C survey to see if we get the same data out of the 4-C surveys that we are getting out of the management review. So there is about -- so we have a detailed review by management, quality assurance contractors, and then we have our surveys that we use. All of that feeds into each and every criteria to ensure that we would properly assess the criteria.

MR. WRIGHT: Okay. If at any point I'm

asking something you are going to cover later on, let me know.

One of the items that we had discussed and had looked at in going through those 40 some odd pages, you know, with the 22 organizations is how do you protect against, in your process, you know, a larger group, you know, carrying the day for one assessment where you have other organizations that aren't looking as well, and you end up with an averaging that kind of averages out the poorer performers up to a middle ground?

MR. MYERS: That's an excellent question. We go around the table, and suppose we are looking at a situation -- this is staffing, you know, and we are getting staffing, and maybe we go around the table, and you have got -- human resources may have three people in their organization, operations is a very critical course, but before we -- we will average -- we will look at averages, but then people come to a consensus as a management team that that average

adequately represents the grade.

If it doesn't, it's not unusual at all for us to say that, because it was always management subjectivity here that operations is a big area, very important area, so we may actually turn a white to a yellow, and we actually -- we have done that before. So we tend to grade harder than the actual grades.

MR. WRIGHT: Okay. Thank you.

MR. PHILLIPS: Let me ask a slightly different question. I heard you say yellow and reds get condition reports, correct?

MR. MYERS: Yes.

MR. PHILLIPS: Now, trending that to what's going from green to white, would that also generate a condition report?

MR. MYERS: Not necessarily, no. We also have a chart -- I don't have it in my presentation today -- but there is a chart where we look at each functional area across here, and we sort of put an X on each function, that way we can look at it holistically and say, is this the

right grade based on what we are seeing, and it's another way to look at it, so we do that a lot of times.

MS. LIPA: I have a question on the chart. The yellow block says all major areas are acceptable with several indicators requiring prompt management action. So is the definition of yellow acceptable?

MR. MYERS: The definition of yellow would be acceptable provided you had proper compensatory measures in place, yes.

MS. LIPA: Thank you.

MR. HOPKINS: We have a question here at headquarters.

MR. PERSENSKY: Lew, you mentioned that you do your surveys, and how are those incorporated into your findings for this roll-up?

MR. MYERS: There is -- it depends. Each department there is ad-hoc surveys they do. There is a specific list of questions that -- I have those questions with me here somewhere, I can come back to them later, from our 4-Cs

meetings. I routinely have a meeting once every couple of weeks with about 30 employees, and then at that meeting so far, I think we have been with over 700 employees this year, and we do a spot-check survey, no names, I leave the room and they can fill surveys out as they want and we collect results of that survey so that we can look at trends and the overall results on a yearly basis.

So that that is an ongoing process, if you will, and that -- the whole time we are in the meeting that survey is used to ensure that it actually addresses some specific questions that ensure we have alignment with the assessments.

MR. PERSENSKY: I guess, if I understand, each manager fills out their own form here for their organization, but the surveys are across the organization, so you wouldn't even know who was answering, since they're anonymous, what organization those people are in when they answer the questions?

MR. MYERS: That is correct.

MR. PERSENSKY: How do you resolve the difference between an individual manager dealing with his own organization as part of it, and then the site-wide survey that's done if it's not related directly to any organization?

MR. BEZILLA: I was -- this is Mark Bezilla. I was going through here, and there are some surveys we use across the sites, and I will say those are anonymous so we get a site perspective, and as Lew said, individual managers will run, I will say informal surveys amongst their people on things like, hey, do you feel that employee concerns are being responded to, any issues that you may be aware of, those types of things.

So some surveys are I will say site wide, but there is -- each department has the option to do informal or formal surveys also, and some of the surveys that we run you can put in which department you belong to, and then we can slice and dice the survey information. It's

anonymous, but we can capture which departments the folks are attached to, if you will.

MR. MYERS: Once again, quality assurance and independent contractors, they do spot checks, and then our quality assurance group, they do their own assessment of safety culture across the site, so once again you get convergence by doing that. If maintenance comes in and says everything is lovely and that's not what they have seen, then they will bring that issue up. So that's the way we get the convergence.

MR. PERSENSKY: I think that's a little bit different than the way Dr. Haber defines it, but that is how it is, a spot-check?

MR. MYERS: That's right. Our process is not identical to Dr. Haber's at all. We cover all the areas, then we have convergence. The good thing that we think we walk away with that you don't get when you bring independent contractors in is the process that we go through allows our managers to have ownership and also allows the management team to go in alignment by

doing that. When we walk out of the room, it's not like someone's hand being up, it's something you own yourself and you come to alignment on, so you are more than willing to go take actions. We think that is a much better process.

MR. CALDWELL: Lew, have you looked through these 40 some odd pages -- there is a number of attributes associated with each of the areas, and then associated with those attributes are the criteria for red, yellow, white and green?

MR. MYERS: That is correct.

MR. CALDWELL: Have you looked at those to see if they are individual showstoppers? In other words, if you have -- your roll-up may be green, but you have red in there say from resources and operations and you're getting ready to talk about restart, and that is a red, even though your overall assessment is good, that would be a showstopper if you are going through and made sure -- in fact, some of the things you may need to grade to say you are ready because of the way it's set up.

MR. MYERS: I personally looked at every criteria on the list, and I have also made changes to some of those criteria. For example, this is a recursive process, some time ago the criteria would be, let's have a policy in place on safety culture, you know, so we have got the policy in place, so that is not a criteria anymore, you know. Now it may be an effective use of it, it starts out at a lower threshold now than it did the first time we used it, so we are constantly improving the process after each and every meeting.

But to answer your question, I have looked at every specific criteria. There would be some areas that if we saw that it was a problem, it would be a showstopper, and us as the management team would grade that harder. That's what we get paid to do, and we'd expect the quality group to do the same thing.

MR. CALDWELL: That would be great.

MR. MYERS: It would be a showstopper --

MR. CALDWELL: Until you fixed it.

And then I was looking at this Page 21, and there is -- if I'm reading it right, there is two reds, one that goes to policy and corporate level commitment area and that is the one on self assessment, and that area grades out as a white even though you have red self assessment, that is an acceptable approach?

MR. MYERS: Let's talk about why we had red, I'm glad you asked that question. The only reason we have the red in place is that our schedule for next year is not in place. We have done self assessments this year, our self assessments are up-to-date, but we grade ourselves hard because we are not meeting the letter of the law of our own process that says our schedule should be out at this time. I would not consider that a limited problem

MR. CALDWELL: Depends on the decision you are trying to make, but --

MR. MYERS: Yeah.

MR. CALDWELL: -- if the decision is what am I going to do today, then that may be the

case, but if a decision is, are we set to go forward in the long-term, that would be a -- you haven't got a schedule for the next --

MR. MYERS: This would cause us to have a high level management action or take prompt corrective action, and that is not next month or next -- you know, next year, that is prompt management corrective action. So that would be coming into the senior leadership team that would take action on it.

MR. CALDWELL: I understand that. I guess what I'm looking at is when would that become a showstopper, what would drive you to fix that? I recognize you put that -- you'd have your CR, but are you saying that it would have to be fixed in a week, a month, a couple of days?

MR. MYERS: Yes.

MR. CALDWELL: Which?

MR. MYERS: It depends on what the issue is. If the issue is we don't have enough SROs in the control room, then that would be a showstopper, no doubt about it. We all know that

that would be a showstopper.

MR. CALDWELL: Even if you didn't and you met your regulatory requirement, but you didn't feel you had enough in order to do the job?

MR. MYERS: That would be a showstopper, yes, sir.

MR. LEIDICH: Lew and I have had conversations in the Mode 5 and again in the Mode 3 phase where we are in here beyond just covered windows, I mean what are the real issues that we have got to get straightened out before restart, there was a lot of discussion underneath the colors too. That is important.

MR. MYERS: In grading something red or yellow, we would expect to be able to look at you, the N.R.C. or the general public and explain why that is not a showstopper.

MR. CALDWELL: And I would expect that that would need to be done, not only for us but when this is all said and done, I assume these things would probably be public and would need to be explained so that it would be clear, that it's

not something that is going to affect the performance.

MR. MYERS: We would expect that also, and our actions we are going to take.

MR. GRANT: We have another question I guess along those lines. This was done to support Mode 4 and 3, is that -- am I reading this right?

MR. MYERS: That is correct.

MR. GRANT: So the red zone here, we are concerned not with showstoppers, I would assume that you had to -- that was a roll-up, and then you had to look at that specifically to ensure that your safety culture supported plant operations that you were going to go into?

MR. MYERS: That is correct

MR. GRANT: How does that measure up, and maybe it's along the lines of what Jim was talking about, definition of several emergency areas do not meet the acceptable standards. I'm trying to weigh that, you know, conclusion for a major block that is supporting plant operations,

so that whole area was deemed to be -- you know, several major areas don't meet acceptable standards, yet overall safety culture is sufficient to support the plant operations anticipated?

MR. MYERS: Let's talk about cross functional work management. Cross functional work management we would consider a problem in our plant right now. Efficiency to schedule is about 60 percent. It was about 40, we are working to get that up. That is primarily due to parts. We understand that, we are not happy with it, but we've got plans in place to improve the schedule, and what's really important is the way we do it is with a schedule, we are not doing things out of sequence, creating unsafe events. We found out we were doing things out of sequence and not using -- adhering to the schedule, and that was causing unsafe -- that was probably a showstopper, okay, so we'd expect to explain that. There is a cross functional work control communications process working. It may not be

working as effectively as we'd like, but we understand why.

MR. CALDWELL: Is that where we rework?

MR. MYERS: Rework would fit in that area, yes.

MR. GRANT: Is this a mathematical --

MR. MYERS: We do it as a mathematical process, and then we step back and do the overall assessment in the entire management team, like this with quality there, contractors there, then N.R.C. will be there to even ask, does this make sense? We have added it up and figured it up, does this make sense, and if it's not unusual once again for us to take a white and make it a yellow, so we tend to grade harder based on what we know, that makes sense, you know.

MR. GRANT: But a red would indicate that a lot of things in that group --

MR. MYERS: Net necessarily.

MR. GRANT: -- need substantial fixing?

MR. MYERS: Yes, sir

MR. GRANT: Thank you.

MR. HOPKINS: I have a question from headquarters.

MS. GOODMAN: This is Claire Goodman, I have a roll-up question via example. The criteria is adequacy of tools, material and equipment, and in that criteria or that attribute, would say a yellow mean that a number of scheduled tasks are not being completed in a timely manner due lack of tools, material or equipment? Now, you did not rate yourself as a yellow, you rated yourself as a white, which meant that a CR did not get written yet, seven areas around the table said they were a yellow. So, in fact, you have seven groups who feel that they have work that is not being completed because of the lack of tools, but no CR gets written because you are a white. I just wanted to mention this is one example of a roll-up problem.

MR. MYERS: Well, we would look at that, our criteria for adequacy of tools is more than 30 percent. Our criteria here is that more than

30 percent of key scheduled tasks are not being completed by the section in a timely manner due to lack of tools, material and equipment. That would be -- that is one criteria. If you want to look at what we consider completely ineffective, more than ten percent of the key scheduled tasks are not being completed by the section in a timely manner due to lack of material or tools.

So, you know -- and we would look at the specific area. If it was maintenance not getting the work done and the material condition of the plant degrading, then that would -- we'd turn that into red, but if it's a -- it can be some other areas that are not as significant, for example, our human resource area, you know, or our -- I will give you one of them. One of them was the computer services group, we did not pull some of the fiberoptics we wanted to get done or something and we grade that red, but it's not significant to the restart of the plant, so when we grade it all out, it may come out as a white, and we would say that was appropriate.

If it was something in maintenance, we'd probably grade it harder, make it a yellow, you know, so you can't say everything is equal, and we wouldn't do that.

MR. GRANT: I guess that is the core of what I was asking as a model, you know, for optics, you know, it just is curious that as you are talking about safety culture there is this model where you have whole areas that are considered to be red, and yet the decision is made to -- that it's okay to go forward with whatever the evolution is, and from an optic standpoint, I wondered what is it communicating to staff that says safety culture is important, but there is, you know, the model that we, you know, put up in front of everybody has a red area, and yet we are going to continue forward with what we were intending to do.

MR. MYERS: We would communicate -- let me give you another example. We did not have all of the personnel evaluations completed on human resources, that they were all supposed to be

done, we turn ourselves red. That would probably not keep us from changing modes, but we would take that on and go get them done, and we did, okay?

MR. CALDWELL: You get our point.

MR. MYERS: I get your point.

MR. CALDWELL: That is -- roll-up is not going to help without going through and specifically talking about the things, just like you did, the individual things. This is a good process, and we just want to make sure that you understand the sensitivity of -- just because something gets, you know, a green and red, the red noses out the rest, but the red is a showstopper, doesn't matter how many greens you have, those are the kinds of discussions we would want to have at -- you know, at the point of restart.

And when you have something like cross functional work management communications as a yellow, and then for your motor change, and then you have a significant rework problem during

the mode changes, do you go -- do you relook at that to make sure you understand because the feed linkage you were trying to reset the timing for got -- you set their linkage wrong, and later when you tested it, you found the linkage reset, I would assume that is a rework?

MR. MYERS: I'm glad you asked that. We have already looked back on that. Actually, the problem with the linkage has been there since 2000, and now that we have gone back and looked at it exactly like you said, we looked at traces on the governor, and the traces were there in 2000, now, with the change we went back, installed a new governor valve, it's tighter around, tighter clearance than the old one, and that new governor valve combined with a linkage had been perfectly aligned, the result is times outside the band, so do we understand that that was a rework problem for us. We wrote out a CR and took a look at the extent of condition.

MR. CALDWELL: When did you put the new governor valve in?

MR. MYERS: This cycle, but the linkage was there and you could see the linkage has been there I think since 2000.

MR. BEZILLA: I think that's right.

MR. MYERS: Now, the other thing we do is once again we publish a list of each one of -- this is a list of every issue that we have and that was graded, and you can optically look at it and tell from both 5 and 4 what the areas of concern were in each area. We'd expect to be able to explain that to you.

MR. LEIDICH: Also in response to your question, Jim, there is going to be -- every time we do one of the assessments we sort of clean off the desk and say, where are we today based on what we see today? I think part of your question is, you are just taking this and taking where you are in incremental improvement and another incremental improvement without any consideration of where you have been for the past several weeks or whatever, so each one of these is a fresh look, and I think that's what -- you know, the

way I looked at it is dust it off and say where in the heck are we right now with an ever-increasing standard and ever-increasing bar. Otherwise, if we look at this over the next several exercises and we are all agreed, we don't have a good tool, that's not where we are at, that's the idea.

MR. WRIGHT: I think there is a comment from the back.

MR. RUETER: I just had a comment on some of the facts that if you go back to your definition of safety culture, and I think what Lew was trying to say is that we applied the appropriate significance to each individual window. If it's very significant, it will be a showstopper. If it's not significant, i.e. lower on the priority, or it's not going to affect nuclear safety, then it's applied appropriately. Thank you.

MR. GROBE: I appreciate your comments.

MR. MYERS: I wish I'd have said that.

MR. GROBE: The inspection team is

continuing its work in this area, and as I mentioned, a number of us have observed these activities. Our sense is that the model to collect data will give you a wealth of information regarding safety culture in the plants. It's not clear to us yet how you interpret that information, and if there is a tremendous amount of management, how on Earth do you come up with the ratings?

We are probably going to be focusing more at a data level in the overall ratings level because it's not quite clear to us how you roll these things up and how you ameliorate a red finding at an individual question and come up with an overall rating of white since many of those individual questions are very important.

MR. MYERS: Right.

MR. GROBE: I'd like to ask one more question, just to make sure I understand. If you have a red or yellow finding at the individual question level that is subordinate to any of

these boxes on this page, Page 21, there is no requirement that you initiate a CR for that?

MR. MYERS: I didn't say that I would expect the group to initiate their own individual CR. If it's up here in one of these boxes you see on the board, then that would get to the Senior Leadership Team level.

MR. GROBE: Okay. I think --

MR. MYERS: It's more significant.

MR. GROBE: A procedure of this nature is fairly unique right now, and -- in the industry, and as I have said in the past, you have earned the opportunity to develop something like this because of the problems -- magnitude of the problems you had. It does give you a tremendous amount of information that we are probably going to want to discuss in the future public meetings. I believe the next time you are planning on performing this type of assessment is just prior to your next Mode 4; is that correct?

MR. MYERS: That is correct, and then we would do a spot check at Mode 2.

MR. GROBE: Okay. We will probably want to talk about that in detail at the meeting to discuss the results of that next assessment, detailed public meeting, just focus on that assessment.

Were you planning on providing your procedure on the docket so that it would be available to us and facilitate that kind of public dialogue?

MR. MYERS: I think -- I thought we had, Jack.

MR. GROBE: It's been -- it's been through six revisions, so if you had, it might not be the right revision.

MR. MYERS: I will send it to you.

MR. GROBE: Okay.

MR. BEZILLA: 7 is in the works, Jack, also.

MR. GROBE: Revision 7. So it would facilitate dialogue during a future public meeting if the procedure was available publicly, and that way it wouldn't be just us discussing

the individual details and procedures, but others could have the opportunity to understand also.

MR. MYERS: I thought I sent you all the later ones. I remember signing a letter, I thought I had. I will look -- I will send it to you.

MR. GROBE: I might have it, so it might not have come across my desk as a public document. I will see if it is.

MR. MYERS: Okay.

MR. GROBE: Other questions about the internal safety culture assessment tool before we move on?

MR. LEIDICH: We are trying to keep objective and subjective here. We don't think it's possible to put an algorithm on a piece of paper that says here is safety culture, we don't think it's a set of opinions by a bunch of managers, so we welcome the back-and-forth dialogue on how to get this combination of subjectivity and objectivity and get the right formula here so we recognize that.

MR. GROBE: It's very difficult to measure attitudes and behaviors, and engineers have a tendency to want to put a number on everything, and we did come up with a viewpoint. I'm not sure what it would mean, I think the details are where the goal is coming from.

MR. LEIDICH: Very good.

MR. GUDGER: For the record, we did submit the last revision to the procedure.

MR. GROBE: Before the next meeting we will make sure the current revision is on the docket.

MR. MYERS: Good.

The next area we want to skip to very quickly, some of the areas that we have actions that we have taken in each area to date. Our nuclear committee, the board policy level is our plant is visited at least four times, the entire board of directors has visited the site to show their support and met with our employees.

Our ECO, Pete Burke, has personally met with all of the SROs to show his support of their responsibility and the CEO, once

again, has visited the site to participate in the all-hands meetings with our employees to stress the importance of nuclear safety. He stayed in the lab all day, not only did he stay at the plant and do a meeting that day, he stayed overnight, until just about 8:00 at night, so that's what I would call a significant commitment in the highest level of our company.

For policy level area also, the new FENOC executive team that we put together, the president sitting beside me has wealth of experience, not only from the company, I'm the new company chief operating officer. As we wind up getting Davis-Besse back on line, my job is to ensure consistent implementation across our site. One of the things that we found, we thought that we had the same corrective action program at all of our plants, and our other two plants, even though the procedure was the same, we called an operability review and operability determination at our other two plants. When we got to Davis-Besse we found out that they call them an

operability justification, completely different word, and that is my job, to make sure that doesn't happen.

So we think this new structure is going to help that, and then Joe brings a wealth of experience in his new role and having him here will develop our processes and get a line on those processes is going to be good, and then the vice-president of oversight reporting to the board of directors and to Gary, you know, one of the things that we looked at, if you go back and look at the previous quality assessment at Davis-Besse, but I have looked in great detail, I have trouble reading the assessment and coming out with the conclusion that the management team was coming out with. Once again, it was isolationism, so we think this new organization will prevent that from happening.

The Nuclear Review Board is changing significantly some of the members, so they changed the structure to stay out of the management area and focus strictly on nuclear

safety. We think that will help in that area. There is a new vision and strategic objectives now that really focus on nuclear safety. And finally, the First Energy Talent Management Program is in place now and will help us ensure that we have the right talent in our plants in the years ahead of us. And we think that if you look at the Davis-Besse plant, one of the things that happened over time was at one time it was the pool for managers and we had a good pipeline of training programs for SROs and stuff like that that went from an SRO program to a site certification program to no program at all, and we just -- from a management standpoint, we can't let that happen.

In the management level commitment area, we think we put a team in place at our Davis-Besse plant. Let me just -- let me -- I will talk about that more in just a second. Additionally, we went down and committed to the regulators that we would ensure that we have the right supervisors at our plant, and the line

organizations, and we brought in an organization I will talk about later, RHR, and that's how we went a lot further than that, we not only evaluated the supervisors, we evaluated managers and evaluated the Senior Leadership Team and up to the president of FENOC. So we felt that that worked well for us, to give us a common understanding of the attributes that we had in our supervisors and managers at the plant.

I'd like to focus for just a second on the next slide, if could I read it. The senior team there is here now, if you go look at the Senior Management Team, we have in place a strong team in Davis-Besse with proven leadership and safety focus. Most of the managers are previous SROs, or at least have an SRO certification. Several of our senior managers have extended experience. For example, you know I was the plant manager when I was in South Texas. Mark Bezilla was in Salem and Perry and has experience from a previous start-up in the past, and then Randy Fast was at the South Texas

plant, and Mike Ross was there through the start-up of 3 Mile Island.

So we think we have a team in here that is a management team that will drive the standards that we want to drive. If you look at the overall team, senior leadership level to give you some numbers, they have over 200 years of nuclear experience in the six players, all have SRO certifications, all have engineering degrees or higher, and four of the six have extensive shutdown -- extended shutdown experience.

In you go down the management level, next slide, and the management level, we made some extensive changes also. That team right now has over 260 years of experience, all technical, which I think is important. Our manager of human resources doesn't have an engineering degree, but all of our technical positions have engineering degrees or technical degrees, such as chemists, which is 11 of 13, and then 10 of the 13 have SRO certification experience. So we think we have a really strong

management team at our Davis-Besse plant, and when the strong management team was there before, the plant performed in an outstanding manner.

I will talk a little bit about RHR International, which was contracted to review our line of managers and supervisors, and they had several of the first review --

MR. GROBE: I'm sorry, just a quick question, I apologize for interrupting. The last slide that you had up there, in some places behind a name there is an A and some places an I. Could you explain what those mean? Behind Farrell there is an A. By the director of maintenance there is an I.

MR. MYERS: Interim alignment.

MR. BEZILLA: Interim alignment. We made some adjustments, initially Greg had reported to Mike, but for this -- the last few months we had Mike and Greg directly reporting to myself, so it's an interim alignment is what that is showing.

MR. GROBE: Thank you.

MR. MYERS: Since we have Mark, he is going to be site V.P., we share the duties, and we did some interim things to ensure that we had a strong management team, so that's what that is.

RHR International was contracted to review the behaviors to ensure that the conferences are anchored and defined. They not only did that once again for our supervisors, but all our managers. They did an overall review of each individual, based on RHR evaluations at round table meetings with the Senior Leadership Team. So they came to us and went through the competencies of each and every one of our managers and supervisors with us. We think that gave us a good starting criteria for actions going forward, and employee development for supervisor and manager level.

We have also done -- we have also added two new categories, nuclear safety and nuclear professionalism to our evaluation process. Nuclear professionalism demonstrates a great respect -- some of the criteria that we

look for there is demonstrates a great respect for understanding nuclear safety, takes personal responsibility for human performance and participates in influencing industrial organization, applies industry improvement, so those are the type of criteria we are looking at in those particular areas, but those are new competencies tied to the managers' evaluation.

One of the things that I believe would have prevented the Davis-Besse event from happening would have been anchored oversight into continuing processes. Oversight just did not serve us well, and I think Greg will tell you that we have taken strong actions, and Corrective Action Review Board and Engineering Assessment Board is now in place. It was not in place at Davis-Besse. We had that in place at our other two sites, it's now an order in our process.

And then the Management Review Board, we have strengthened that review board to ensure that CRs are properly characterized, and we didn't have an identification problem, we

thought our threshold was fairly good to begin with, even though -- but if you go look at some of the CRs, they were not properly characterized, and we think that we fixed that problem.

Also anchoring the management work practice area is the risk management process to ensure management oversight, so each week we look at risk management and risks associated with the job. Going down to the next to last area, based on risk, assign managers to specific jobs, you have a management observation program, a bean count, watch the same guy do the same job every month, because we ain't got the observations done. That did not serve us well. We now assign managers to jobs based on risk, and we sort of make sure that we are getting all of those management observations done that we scheduled. It's important that we give management a sense of the right job, and those two processes are helping that.

MR. THOMAS: Do you have any data to say how effective that management oversight has been?

MR. MYERS: In fact, I have got a whole book here with me.

MR. THOMAS: Condense it a little bit.

MR. MYERS: Why don't you let me get back to it later.

MR. THOMAS: Okay.

MR. MYERS: And we will --

MR. VON AHN: I will be discussing that in my discussion.

MR. CALDWELL: Just to clarify, your definition of risk is most safety and risk to the plant, or --

MR. MYERS: Risk to the plant or risk for job to either tripping the plant, causing an event, you know, so we look at systems, a list of systems and tasks being performed on that system.

MR. LEIDICH: My process for all stations, well, if there is a risk-significant activity going on at one of the plants, even if it's off shift, we handle whatever. There will be strong management observation of the activities to make sure it's done properly.

MR. THOMAS: So this is the additional oversight that is given ensuring freely-performed testing?

MR. MYERS: Yes.

MR. THOMAS: That type of thing?

MR. LEIDICH: Also routine surveillance, so it's a matter of what's the risk that we feel is necessary to provide the oversight.

MR. THOMAS: Okay.

MR. BEZILLA: Just two things: Scott, we created a new procedure, it's an EB something, something 800, and that is for Modes 1 and 2, and that will identify for what management process low risk, which would mean the supervisor. Medium risk would be manager attention to that activity for that day, and then a high risk would be a manager and direct level overseeing that activity.

It can also be an infrequently performed test or evolution. This is true of the work management process, and that is a new procedure that we put in place at Davis-Besse, it

hasn't been in Mode 1 or 2, but exposed the work operators for that, and we will focus on making sure that they are ready to go on the chance we get in the Mode 2 and Mode 1.

MR. THOMAS: So this will supplement your IP frequently-performed test guidelines?

MR. BEZILLA: It's a lower level, gets more management attention sooner on activities.

MR. MYERS: The answer to that is yes.

MR. BEZILLA: And just one more thing. It is plant equipment risk, can also be like high -- potentially high radiological evolution. As an example, when we did the reactor vessel head, removing of the nozzles we had a review meeting, determined that that should be an infrequently performed test and evolution and treated that with I will say additional respect that it was due, based on the potential that we have contamination and/or dose absorption by our people. And I think we did that job for about half the projected dose, because I think we had the right management attention on that evolution,

so we could use it there to -- Jack just said any vessel would have an RP supervisor briefing, and they would have that at the jobsite also.

MR. CALDWELL: What about like -- what about if you were at a situation with the plant where changes in pressure could result in initiations or activations, or were those recognized as high-risk activities?

MR. BEZILLA: Those evolutions for this normal operating pressure test, what we had is, we had the normal crew complement -- actually, double crew complement and had an infrequently-performed test or evolution oversight individual, which was our op superintendent individual, and also had select managers and directors, and a few SRO types that will provide management coverage, observation and coverage through the normal operating pressure test, actually had that through the entire test period here.

Now, has that prevented us from having any mistakes? No, we have had some

opportunities on the way up, we had one last night that we talked earlier about Scott being there, and we haven't prevented those. But this dress rehearsal that we have done I will say the normal operating pressure test has fettered out the things that we were looking for, whether it was plant issues, people issues or process issues.

But the intent of the management oversight is to minimize or lose the potential errors or mistakes or events.

MR. CALDWELL: And it hasn't demonstrated itself to be very effective?

MR. MYERS: That is not necessarily true. There has been several issues that we have actually caught, you know, and we briefed you on that yesterday, but there have been several issues that we have caught during that process.

MR. BEZILLA: Typically we don't talk much about the successes, we only talk about the failures or opportunities.

MR. CALDWELL: Right. Because you're at a

situation where failures are intolerable, so that's what it comes down to, and both these situations if there was oversight, they obviously weren't looking at the history of implementation that would have given them the opportunity to get ready to either hit a trip set point or getting ready to cause a corroded tank valve to open, and that was my point.

If there was a lot of oversight there, it wasn't helping at the time. First of all, I expect the operators to have caught that, not to have let that occur. And then you had additional ROs and SROs and oversight for both those evolutions, and that was ineffective in preventing those things from occurring.

MR. MYERS: We would agree with that.

MR. LEIDICH: We recognize that we have got work to do, both in terms of operator performance, management oversight, and we have learned that loud and clear over the last year or so, so we are --

MR. MYERS: There is some improvements we

can make.

MR. LEIDICH: -- absolutely in the highest level of attention.

MR. MYERS: One of the things we have used, and I shared with Christine earlier, is a document, you know, and it's a really quality document, and it looks at several extended issues of how to ensure operators are ready. The whole -- one of the many purposes of the seven-day evolution was to find some of the issues that we have. We don't like finding those issues, but we won't have those issues again. I guarantee you that we will not have another problem with the accumulator --

MR. CALDWELL: I'm not worried about the accumulator flood tank necessarily as I am making sure that the rigor is there such that you are not going to have any other occurrences, and if you have one, the only way in which you had an opportunity to learn from and to provide feedback to the operator, that that was unacceptable, and you had one coming back down, which would

indicate that they didn't get the message, so it doesn't give us confidence, I guess, in those evolutions and the oversight.

MR. GROBE: You know, your individual commitment area back on Slide 21 had drive for excellence, questioning attitude, rigorous work control and prudent approach, open communications and nuclear professionalism. You were correct in the sense that this evolution was performed in a way in which there was minimal risk, nuclear safety risk.

MR. MYERS: Right.

MR. GROBE: If fuel is essentially cool, there is very little risk of any sort of safety consequences. Nonetheless, I would not have expected the types of operating problems that were observed, especially given the fairly high set of marks on your safety focus and individual commitment.

And this goes right back to the questioning attitude, rigorous work control, prudent approach and nuclear professionalism.

And I asked the question before the meeting started, how many plants are you aware of that have two safety feature actuations a year, and let alone a week, and it's troubling, and it also -- I think Jim asked the question earlier on your assessment process and what it tells you and what it's telling you right then is based on what you are seeing in the evolution.

MR. MYERS: One of the things we do is, evolution is going to be a large part of our assessment process to go forward, and that is, we thought we were briefed on that yesterday, and based on all the drills we ran and the assessment done, we learned from that, and, you know, we figured out that -- we will share now -- is that our procedures in some cases are not as specific as they should be, and they are not utilized the way that we are used to seeing them utilized on the other plants, so we will effect actions, okay?

MR. GRANT: Just to reflect on something that Mark said, and I'm sure you probably didn't

say it the way you intended, but you used the word the evolutions over the past week, you know, ferreted out, and I don't think you meant to say that you are using the plant or the evolutions to discover problems, you were actively trying to find those sorts of issues before you did the plant evolutions, you are not using those evolutions to ferret out problems that might be there. You've got to take advantage of the situation if it occurs, but you're not using the plant or these evolutions to discover problems, right?

MR. MYERS: That would be correct.

MR. GRANT: Okay.

MR. MYERS: The last thing I want to talk about, the slide, was what I consider a success, and this is the seven-day evolution that we have done, and that is the use of our problem-solving, decision-making process. In my mind, and I really do believe this, it's a rigorous approach to taking on issues with the right team involved and putting the right, best and brightest you

have in place. And an understanding of the issues is a key to ensure that issues like the reactor vessel head doesn't happen, and one problem is isolationism. I really believe good problem-solving would prevent us being here today, and I also believe it would help us solve a lot of issues that we found in this seven-day test.

And from a breaker standpoint to other issues that we found, each time I was extremely pleased with the success. what I will tell you about is the fact that I did not have -- Mark did not have to take our organization and tell them to stop, put a problem-solving team, sit them down, write it all up, make it visible and go forward from here, you know. In my mind, that was a success, and I think that one process change alone would have prevented us being here today.

MR. THOMAS: Do you believe that they also effected prompt corrective actions? I would agree with you that when an organization is

confronted with a problem, they assemble a team that starts evaluating. Would you say that, one, they determine that the cause corrective actions were prompt?

MR. MYERS: What I would say is they don't come out of the gate as quickly as I'd like to see them come out, you know, and I think we got great evaluations, not as promptly as I would like to see.

MR. VON AHN: I will speak to that in my discussions, because Q.A. would have liked to have seen a little less of a learning curve on this, and I will talk to that issue of the problem-solving discussion.

MR. MYERS: And the individual level commitment area we know we have done a lot to strengthen our organization and get alignment. We have done the case study training, run 4-Cs, town hall meetings, refocused on the site on-line articles. Right now when I go do surveys, one of the questions I ask is about communications.

About 86 percent of the people in

the plant would rate our communications fair or good and -- which is a big improvement from what we had a year or so ago, so we have worked out and communicated with our people.

And then finally the management observation program allows our managers to interface with the employees better and ensure that we have the right standards. I still don't believe, once again, we are getting the bang for the bucks that we should here, but it's a big improvement over what we had before. There is still some room for improvement.

In the supervisors area, we have completed leadership training. The employee standards training, safety conscious work environment training, that is training for every employee on the site, problem-solving, decision-making, and then finally we have a new document that is coming out called a New Employee Orientation Manual. I just looked at that last week and Randy's the -- I think the sponsor for that. So we think that is going to be a fine

document. Also we'd welcome your opportunity to comment on that.

Let me move on to the definition of safety conscious work environment.

MR. GROBE: I think this is a -- kind of a whole new topic, and I'm sure we are going to have some questions and dialogue. We have been going for about an hour and a half, why don't we take a brief break and give our transcriber a minute to rest her fingers, so let's reconvene at ten minutes after 2:00.

(Whereupon, a recess was had, after which the meeting was resumed as follows:)

MR. GROBE: Go ahead.

MR. MYERS: Thank you. The next area is part of the safety culture and safety conscious work environment. That is an environment in which employees are encouraged to identify problems, are confident the problems will be effectively evaluated and corrected and are

protected from any form of retaliation as a result of raising safety issues or raising issues.

You know, we think that we've made great progress in this area, and that our program is proactive rather than reactive. The program we have in place now, just some statistics for you guys on the 700 people in the past year that we have surveyed in the 4-Cs meeting, 100 percent of the people say that they would use the Corrective Action Process, which is the first part of the safety conscious work environment process to identify a problem, 86 percent of our people indicated safety conscious work environment is -- confidence is a good increase. 93 percent of the people would bring a concern to the safety conscious work environment if they have one that cannot be resolved. 98 percent said they would bring the current concern here to their supervisors or the managers. So we think that is really a strong message there, the supervisors or managers. 97 percent said they

would use the N.R.C. if they needed to, so we are one percent higher. 94 percent indicated that concerns that they have made in the past were treated fairly, 94 percent, so that is a good number.

And then once again I gave -- this 87 percent right now would indicate that our communications for employees are fair to good, which we are pleased with. Also, we worked hard to focus on communication in our program. Now, one of the things we had before in the ombudsman program was a strictly wait and see. If somebody had a concern, the program was not proactive. The method uses telephone, faxes, drop boxes, company e-mail, face-to-face communication and exit interviews to go out and specifically look for employee concerns.

MS. PEDERSON: The statistics you mentioned, do those include contract force?

MR. MYERS: No, they don't, they include our work force.

MS. PEDERSON: Some of the other things

that you talked about, exit interview and things like that, does that cover --

MR. MYERS: That could cover contractor employees, yes.

MR. CALDWELL: So percentages that you used, what percentage of the staff is that, all the staff, or --

MR. MYERS: We have had 4-C meetings, there have been 700 people that we conducted surveys with.

If you look at our model, safety conscious work environment, the four pillars, management support, we have really anchored our management support and policy LP-2003, we specifically have a policy in place now that encourages strong management support for our safety conscious work environment program, problem-solving and our company process we think has been strengthened in that we now give feedback to each and every employee, and how would he solve the problem, what we do with the problem is we issue an e-mail, we make sure we

get feedback.

The effective alternate resolution process. We have used this process several times during the past year. It's a new process. If you have a concern that you can't resolve, it's a way to bring a third party in and look at that concern and try to resolve it. We think that program is a -- the feedback we are getting is that program treats people fairly and with respect. And then we have -- we wanted to make sure that people didn't feel like they had confidence in our program, and one of the things we have done to prevent retaliation is evaluators are independent, before we would send issues to the departments for review, and we weren't getting marks on the confidentiality we would like, so now we have an independent evaluator and we think that really helped our program.

From the first pillar, the management support, worker confidence, once again I mentioned the policy that we have trained all of the managers and supervisors in safety

conscious work environment and trained our operator on safety conscious work environment, the CAP program if you will.

MR. WRIGHT: Before you go on to the CAP program, you indicate here that you have trained all the managers, supervisors and operators on safety conscious work environment.

How about the rest of the staff?

MR. MYERS: We have not done formal training, we have rolled out the corrective safety conscious work environment program to the staff. Can we get to there is a training report for that? No. But our marks indicate that we have gone out of our way to make sure the staff understands our safety conscious work program.

MR. WRIGHT: Is that something you think just a roll-out that way as opposed to some specific training with some periodic training to keep them apprised and understanding of where it is, and that is going to be as effective as doing a more formal program?

MR. FAST: That is captured both in the

employee orientation manual and as part of a general employee training annually, so it's reinforced each and every time an individual requalifies to gain access to the plant, and as well as new employees get that through orientation.

MS. JARRIEL: This is Lisa Jarriel at headquarters, I have a question on that line you used to investigate the safety conscious work environment action plan, a specific task, to do formal safety conscious work environment training for all employees. Can I ask why you decided not to do that formal training?

MS. FAST: Lisa, it was my understanding we were doing that, but I don't know that I can verify that, so let me take the action to verify that fact, because we were rolling that out, and I don't know that we are actually capturing that in our training process. It fits, so it will allow me to take the action to close that gap and figure out did we actually do it or not, and then we will evaluate if we didn't that we should,

because it certainly is part of our ongoing program.

MR. MYERS: We rolled it out over and over again with our employees. Our employee margins indicate that they understand our process and our programs really well, but part of the systematic approach to training, the answer to that is no, and we will reiterate that in the new employee training.

MR. BEZILLA: Let me help here a little bit. When we actually rolled it out, I was at Beaver Valley, and they were requesting us to roll out -- it was a safety culture policy, as well as had a safety conscious work environment letter Lew had written, and we captured -- we talked to all the managers, talked to the supervisors, and rolled that out to our employees, and we captured that all in records, so I -- at least at Beaver Valley I thought that was FENOC-wide based on your request.

MR. MYERS: We did that and we did it FENOC-wide. We also, at an all-hands meeting,

went over the process we had with the ombudsman, we came in -- not employee concerns, personnel came in to present an all-hands meeting, stuff like that, but I went to the systematic approach to training, and said can I show you what we have, we will do that as part of the general employee training, training our employees to understand the process that we -- I would say we have trained them on the process. We have communicated very well with them getting good marks.

MR. GROBE: Is the training you provide in your general employee training the equivalent level to what you were providing to the supervisors and managers?

MS. FAST: Let me answer that. What we provided, what is on the slide was done by Morgan Lewis, by an attorney, that actually provided some of the details on the regulatory requirements, and the laws that really back the process. So that was the formal part that I believe Lew is talking about.

That was done in a very formal setting, it was about four hours of training. In fact, in preparation, just talking to Art Lewis, that was pretty a detailed kind of training. When you get it from an attorney, there is a lot of focus on the actual legality associated with it, and the need for strict compliance we will say. The part that Lew is talking about with all of our employees was more of the conversation in talking with our managers, not so much in the legalistics approach, in a regulatory approach, but in an environment approach what we expect of our employees and what those employees should expect of us as the leaders of the station. So I believe that's where the little bit of difference is between what we actually rolled out to supervisors, managers and our operations folks, because of their leadership role, and then what we actually provided to our individual contributors.

MR. GROBE: Thanks, Randy. Just a follow-up to that. Have you done anything to

measure the level of knowledge or understanding appreciation on the part of your supervisors and managers of the details of that training, and is there any plan on periodic retraining in this area?

MR. FAST: Well, the answer to the first question, Jack, we did have a test, so there were case studies, and an actual examination that was performed to ensure that the individuals understood. We have not retrained at this point, and I would say as well we are not in the retrain period. We will have to have an evaluation that is part of the ongoing annual training, but is it the same detail? The answer is no, and we will have to evaluate whether we could do that going forward.

MR. GROBE: Okay. Thank you.

MR. MYERS: The corrective action process is a key foundation. We know this is an area that we made improvements in and we need to continue to make improvements. We made process changes, we think the -- we trained our employees

on process changes. We have had an independent validation process now, and we think we have strengthened the root cause process.

The next pillar is effective Alternate Problem Resolution process. The program became effective 12/30 of 2002. We benchmarked our program against several other utilities, Millstone, Diablo Canyon and others. That program was reported directly to Fred von Ahn, the vice-president of oversight. We protect confidentiality, and once again we have an independent -- we think the program right now -- my real belief is that would give us very high marks by anyone outside the agency. That program works extremely well for us.

MR. CALDWELL: I just got a brief on this yesterday, and I understand a couple of the key players in that program are no longer in the program, it's down to half, or --

MR. WRIGHT: It's our understanding that some of the investigators, the same group that was there originally is not there any longer, at

least some of the players.

MR. MYERS: A lot of those people were contractors, we bring them in as we need them, but, you know, we have got permanent personnel there in charge of safety conscious work environment, so we have announced our key manager, and as we need independent evaluators as case loads require, we bring them in.

MR. WRIGHT: One of the things we noticed, as Jim said, when we tied the information that at one point I think you had four investigators, three contractors and an internal person?

MR. MYERS: Right.

MR. WRIGHT: It's our understanding that you have one contractor and the internal person, and when we combined that as -- looked at some of the statistics where the timeliness of the reviews has gone from about 33 days to 120 some odd days over the course of about a month, kind of raised our eyebrows a tad as far as the timeliness and getting back to people, particularly when we see reduced staff there.

MR. VON AHN: We will look at that. As Lew said, because the level of activity has gone down, we did reduce the contract level. We do have, as you said, the one independent contractor, as well as the in-house individual. The timeliness I will look at further, but there were some significant issues we were looking at in timeliness of the investigation is depending on the significance of the issues, but that is a good comment that I will continue to look at, and if need be I will bring additional resources to bear.

MR. BEZILLA: Let me help, Fred. On the quarterly assessment that the team puts out, there were two annual timeliness issues, Jack. What they said here to me, they gave me this update on a quarterly basis. They said that the indicators were declined. However, there were several complex issues that had to do with corrective actions process items and warranted a greater amount of time to evaluate, and that was the cause of the timeliness resolution of the

employee concerns issues. There were a couple of sticky wickets, if you will, and that's what caused the timeliness to drop.

MR. MYERS: It was -- it wasn't a backlog issue.

MS. PEDERSON: Can you give us an ECP?

MR. VON AHN: There is a slide later on in the presentation, later on in the presentation.

MR. CALDWELL: We are not trying to get into resources you need, we just looked at the two indicators, reducing resources, increasing in time and wanted to ask the question to understand if they were related

MR. VON AHN: No problem.

MR. MYERS: And the last pillar is Environment Review Team. We charge the team, the team we use oversaw our contractors reduction effort, we think we managed that well, and the team actively looked for issues that may give any kind of perception of discrimination. We think that team is doing well also.

MS. LIPA: Do you have examples of where

that's had value, that team, or are you going to get into that later?

MR. VON AHN: We get a quarterly report from the safety conscious work environment team leader. The first quarterly report indicated 15 percent rejection rate due to safety conscious work environment issues that could have come up. The second report, which was July 30th, indicated a 13 percent rejection rate, so we do see a positive trend here as well so that that team is ensuring that safety conscious work environment issues are upheld.

MS. PEDERSON: Can you give us some insight as to why the rejection rate is, what are they identifying that causes them concern?

MR. VON AHN: There is a checklist that the Review Team is going through, and if there is any hint of any kind of retaliatory action or anything like that, the Safety Conscious Work Environment Team would reject that, so the check would say this person has initiated a possible condition report that showed that this could be

construed as retaliatory issue. So those are the types of issues that the team will see and reject as a result of that.

MS. PEDERSON: Is it an issue of there actually are retaliatory actions that are being proposed, or is it an issue more of the ability to defend the position for a legal standpoint, can you help us there.

MR. VON AHN: I think it's a bit of -- it's unawareness on the managers' part, and so the Review Team gives an additional look at the issue and is able to provide a broader perspective than possibly the manager might see by utilizing this checklist, plus the team membership, you look at the various human -- you have an HR representative so you look at that aspect, you have a legal rep so that aspect is looked at, so you have a broader perspective on the issue than just the individual manager could bring to bear, and that is the cause for some of the rejection.

MS. PEDERSON: Are they brought back into the Review Team and further approved, or are

these actions that are never carried out?

MR. VON AHN: The team would make a recommendation based on their assessment of the issue, and that action would be either changed or deferred all together.

MR. BEZILLA: Cindy, I have been in on a number of those at Davis-Besse in the last couple of months, and typically it's -- the evidence doesn't support the required action necessary that managers need to either strengthen their support or need to change their desired outcome. And those cases, in fact, in I think all cases they come back and there is additional information, right, because we understand what you want now or we reassessed this and talked to our peers, and based on that, we want to take this action, and then what the team does is make sure that there is a preponderance of evidence that support the desired actions, and also help balance the action requested, okay, because we can see if there is some kind of anomaly, and provide that feedback to a manager and/or

director as appropriate.

MR. WRIGHT: Mark, as you -- what struck me as you were describing a Department of Labor type of review as opposed to a safety conscious work environment review where you are looking at the preponderance of evidence, you are looking at these kinds of things, does the evidence support the action being taken as opposed to a review that says, even if I understand the action and I can support the action and all the rest of that, what impact is that going to have on the organization or people within that organization, and I think that is -- you know, HR does a lot of things in supporting the justifiable action to take. The SCWERT needs to be looking at -- what we would look at is what impact is that going to have on the organization from a cultural standpoint, how does that tell me how you fit that second piece in, given what you were just talking about?

MR. BEZILLA: That's actually the primary piece, Geoff. The question was when do these get

kicked out? Typically, they get kicked out for the other piece, the piece about do you have evidence, is this a balance, right? The first piece is, hey, is there any harassment, intimidation, retaliation or discrimination that could be thought of, inferred or otherwise observed either by the individuals or by others. That is the primary focus, but then we also talk about, does it sound right? So it's both those pieces, checklist walks you through, and it covers your piece you talked about.

MR. VON AHN: The primary checklist, the checklist goes to the retaliatory issues specifically, but as I said, the broader perspective is legal and, HR is to get a good broad look at the issue.

MR. WRIGHT: The second question I have is one we have raised before, is that safety conscious work environment is an umbrella over the entire site that is, you know, your employees as well as all contractors and the like. Can you give us a bit about your perspective on how

SCWERT, you know, is or is not dealing with the contractors' piece of this, beyond the reduction in force kind of activity that you indicated as being, you know, has been addressed.

MR. BEZILLA: We have not -- what we have done is with our contractor we say, hey, how do you handle potential harassment, intimidation, retaliation, discrimination issues, and we listen to what they do, and then from a SCWERT perspective I believe to this date we have only addressed the reduction in staffing. What is your plan, is there any issues there, so we have not gone on into individual issues with the contractors and what they might have with their management team, if you will, the supplier of that resource.

MR. VON AHN: It's the up-front address of ensuring that the contractor has in the program adequate criteria and judgment in there, and if there is a hiccough or a question about that, the Safety Conscious Work Environment Review Team would get involved, but we review that up front.

MR. WRIGHT: That is the program for laying people off as opposed to taking some action against an individual short of that, correct?

MR. VON AHN: Correct.

MR. MYERS: Correct.

MR. WRIGHT: Okay.

MR. GROBE: There is quite a few issues now that have this type of a function, I'm not sure they all called them SCWERTs, but have you benchmarked your procedure against other sites that have this type of program?

MR. MYERS: Yeah

MR. VON AHN: When the procedure was developed, that was done.

MR. GROBE: Okay. Just one other question, the -- originally when you looked at the chart, I haven't looked at it recently, but I believe that provided not only this activity-specific function where if a personnel action is coming forward, the Safety Conscious Work Environment Team would look at that, but there was a quarterly overall assessment and advice to management on the safety

conscious work environment?

MR. VON AHN: Correct, I have two issues, April 21st, July 30th.

MR. GROBE: So that is now being accomplished?

MR. VON AHN: That is correct.

MR. GROBE: What sort of considerations go into it, is it simply a report out on the specific personnel actions that have been evaluated, or is it a broad assessment?

MR. VON AHN: Correct. It will assess and evaluate a number of meetings, number of actions. It will look at the number of rejections, the types of rejections and evaluate those, and to evaluate the program health. It also balances the SCWERT people activity with employee concerns and an allegation activity to see how we are doing in all those arenas so we have a broader picture.

MR. BEZILLA: The latest report tried to expand on what they were providing to us, to management, and what they do is -- here is the

words, it says provides a proper program for corrective significance review and process based on analysis, specific performance indicators. So they take not only the things, but then they have got some performance indicators now for each of the pillars, and then they take a collective look and try to provide us a collective significance of here is what we are seeing among the pillars, if you will.

MR. GROBE: Last fall, I believe it was in August, and again in April, February, March, April, I can't remember the exact month, you did a safety conscious work environment evaluation. Is that done on the auspices of this Review Team, or do they consider those evaluations somehow in developing their assessment, and when is the next one you would be completing?

MR. BEZILLA: I can ask for some help?

MR. VON AHN: The next safety conscious work environment survey will be done in November after the roll-out of the Ed Ventures. Actually, I have some discussion on my slide on the March

survey, some contrast of the 2002 survey.

MR. GROBE: Okay. So that is not under the auspices of the SCWERT, the Review Team, or is that survey being done independently?

MR. VON AHN: The survey is under the umbrella of the four pillars, I believe it's under Pillar 1 would be the survey results. Yes, it's Pillar 1, health assessment results.

MR. GROBE: Okay.

MR. MYERS: When Gary started out, we think we are building a proactive safety team that has people who plan the process, and our present stage, as you know, we just finished heating the plant up for seven days, we saw some -- we saw issues that we talked about earlier. From a plant standpoint, our plant worked very well, it was leak tight, we were very, very pleased with the leak risk. We had -- we demonstrated a new leak risk process that we have for identifying very low leakage. It identified I think .001. We can see that, and that worked well for us.

Additionally, if you go look at

the workmanship we saw, we packed a couple hundred valves, and the problems we had, we thought was good. The process that we saw, our troubleshooting process -- troubleshooting process and decision-making process worked well for us.

Additionally, the work that -- the new system that we installed, which is one of a kind, it's unique in the industry, that people can look to the flew system, will tell you which one it is throughout the cycle. We did a cleanup test and proved that it can detect very low humidity, but overall we accomplished a lot in the last seven days, from a transition from an outage to an operational organization, we are using the operating experience manual that we talked about earlier.

We looked at the problems at the other extended outages, specifically at Salem, Fermi and whatever. During the seven-day test we went back and did as much testing and we could on the modifications. I think we closed that up. I

think workers -- there were lots of work orders that were PMT testing, so that was successful.

The slow heat up and testing of the equipment ensured that the equipment would work well. And the most difficult thing, if you look at that document for lessons learned, is the transition to an operational phase attitude, if you will.

One of the things that document indicates is -- I looked at it this morning -- that we have to sharpen our skills as the operators of a not operating plant in over 19 months now, so we think that even though we did have some issues, that we are getting the issues resolved, and we will be better for this seven-day test.

That wasn't the total purpose of that test, but there was some real lessons learned on heating up the plant, getting to a normal operating temperature and watching how our program and processes and procedures work.

I will go to a couple of overall

indicators. If you look at, we are having trouble with all the CRs, getting time to review the CRs. We had a level of 95 percent, and we are meeting that goal as we speak, and consistently reviewing the CRs within one day at the SRO level. Next slide.

The self-identified rate, you know, we had a goal of 85 percent there and we think that we are making good progress there. We'd like to get up to 90 percent, and we are close to that. We just need to keep trying to lower that threshold. The next slide.

The area that we have concern about is the root cause, and I would tell you in my mind, root causes -- the root causes, even though the quality indicator here would say that, you know, that we have had a decline in the root cause at the present time, I will tell you that based on some of the comments we had after the investigation, we have lowered that threshold again, and that is causing a decline. We expect to see that curve getting back to the right

direction, and -- in root cause, and we will make sure that that happens, but that is not meeting the goals that we would like now.

MR. THOMAS: Lew, what type of things are they identifying that are causing rejections of these root causes?

MR. MYERS: Scott, I think some of the things I have seen is some of the causes -- not addressing all the causes, not completely addressing all of the causes. Another level down, there's been some issues of that -- like that where there has been some additional contributing causes that were identified.

Additionally, there has been some indications of where the corrective action cannot directly link back to the root cause. We have had some issues like that too.

MR. THOMAS: Are there any cases where the individuals performing the root causes weren't qualified to do so or don't have the proper training to carry out those type of evaluations?

MR. MYERS: I've not heard of that lately,

no, no. Have you heard of that?

MR. BEZILLA: (Indicating.)

MR. MYERS: No, it's not something we have seen.

Individual error rate, and that has to do with the number of errors you see in 10,000 hours. We would like to get that down further than what our goal is. Long-term goal is .29. We start at .35, and -- but we are still not happy with that. We are having too many errors, and some of them were more significant than we'd like to see.

Program and process error rate, once again we are in the .3 of 10,000 hours, but, you know, we think the last seven days we need to improve on. Engineering quality of the products, the average weekly score there is an -- is below 1. We are real pleased with that. That is something we continue to work on to keep the quality of our engineering products, and especially in mods in good stead, but --

MS. PEDERSON: Can you tell me how you

determine the quality of these engineering products?

MR. MYERS: Yeah, we have an Engineering Review Board that reviews the engineering products, the mods, if they are rejected then that would be -- in other words they have to go in there if they are rejected, if it's minor comments, we wouldn't consider that in the number of rejections.

Management observations, you know, once again this is good news, that our management observations were hitting the mark, and that we are at a 12-week rolling average of those we are scheduling is up above 90 percent. But once again, if you ask this, are we getting the bang for the bucks, we were not getting as -- we don't think -- we think that people we bring in from the outside are more critical than our own managers in some cases.

Go ahead, I know you have a comment.

MR. THOMAS: What does completed mean?

MR. MYERS: That means that the management observation was performed in the data base.

MR. THOMAS: So if they filled out the form, then that is completed? I'm trying to understand.

MR. MYERS: Well, they did the things, did you give the feedback questions on the form, did you do -- yes, that is completed.

MR. THOMAS: So this doesn't give you any information about the effectiveness, just tells you they were done?

MR. MYERS: This indicator doesn't -- I have a book here that gives you indications about the effectiveness on coaching. There was perceived increases in coaching that we didn't see before, seeing improvements there, but I have got last month's performance indicators. If you want to see those afterwards, I have a got book of my group.

From the 4-Cs meetings, once again I met with my 700 employees, you know. If you look at our 4-Cs it has had an open forum. Let

me tell you how this works. We bring in a facilitator, facilitator meeting with a team, they address a list of questions, which is provided to me prior to the meeting, and then I go down and meet with the employees for about four hours. One of the things that I always focus on in those meetings is safety conscious work environment and safety culture. Those are two main topics, that even if they don't ask questions on, I make sure I cover. Before I leave the meeting, I give my employees a copy of our business plan, it's marked up, talks about safety. I give them a copy of some other performance things that have recently happened.

I found those meetings to be very, very good, and I have gotten overall good comments back from those. From those meetings we've captured -- one of the things that we take actions on. One of the things that we are getting feedback on is some method to see the company -- see the actions that were taken. I have not formalized that process, but at our

other two plants we take the actions from the 4-Cs and put them on the web page, and we are starting to do that, and the people are tracking what we do.

There's been actions we have taken to change the meeting, you know, and we have taken those actions, but I don't think I'm feeding back where that came from, as well as I just know it's happening.

Management review items to consider improvements, coming out of those meetings, they have given me a whole bunch of actions that were taken, and from a management standpoint, we have taken those actions. Some of the big things is like the 6/30 meeting, you know, making sure that we focus on the problem or goals of not shooting the messenger necessarily, so we are real blunt in those meetings about some of the things you should do. And we have taken actions in each one of those areas.

That finally concludes my presentation. I'd like to turn it over to Fred

Von Ahn if you don't have any questions.

MS. JARRIEL: I have a question before we go on to the next area. It's Lisa Jarriel at headquarters.

In regard to SCWERT, I think a question was asked about the effectiveness of the SCWERT in avoiding discrimination issues and claims, and one of the attributes in the restart readiness review plan is just that, effectiveness of SCWERT in avoiding discrimination complaints. Revision 6 -- between Revision 6 and -- 5 and 6, the criteria was changed, and I wanted to question why specifically. Red used to be that there were five or more N.R.C. allegations or ECP concerns of discrimination submitted within the past year, and now it's within the past six months, so you have made it harder to get red, and I wondered why you changed that criteria.

MR. VON AHN: Could you just repeat that one more time? Initially we had if there were five N.R.C. allegations within a year we would turn red, correct?

MS. JARRIEL: Yes.

MR. VON AHN: Now in a shorter period six months, if there is five allegations, we would turn red?

MS. JARRIEL: Right.

MR. VON AHN: So, in fact --

MS. JARRIEL: You have had five allegations at the N.R.C. in the first three months of 2003, you have one more in the next three months, and so it's gotten harder to get red, and I just think that is a less conservative attribute, criteria, I'm wondering how you came to that decision.

MR. VON AHN: I need to review that with you off-line because I'm not understanding. If I have five cases, now I've shortened that to six months, I must be misunderstanding something.

UNIDENTIFIED SPEAKER: It turns red quicker. If you have three allegations in the first six months of a year and then you have another three allegations in the second six months of the year, you don't hit red and yet you

have had six allegations in one year.

MS. JARRIEL: It now makes you yellow or white.

MR. VON AHN: We will look at that and correct that, Lisa.

MR. MYERS: That's a good comment.

MR. VON AHN: That was not the intent, as evidenced by my response. We will correct that.

Today I'd like to discuss oversight effectiveness of some of the actions to improve safety culture at the Davis-Besse station. There are four areas in assessment of safety culture effectiveness I'd like to address today.

The first area is station attention to safety conscious work environment. This is such an important subset of safety culture. The second item I'd like to discuss are the actions leading to Mode 4 as they relate to safety culture. The basis for these discussions will be the quarterly assessments as well as special assessments completed during -- prior to

Mode 4 testing by quality assurance.

Next I will discuss the observations during Mode 4/3 execution. These will be discussed as they relate to the model developed to observe the normal operating pressure, normal operating temperature testing activities. And finally I will draw conclusions as to what our observations are telling us with the data to date. Next slide, please.

In the area of safety conscious work environment, some of the primary actions that have been completed are an Employee Concerns Program initiation, completion of two safety conscious work environment surveys, and Safety Conscious Work Environment Review Team initiation.

The ombudsman program was a program that was transported in late 2002 to a more formal employee concerns program. The ombudsman program was more of a referral type program, transformation to an employee concerns program, gives a more independent organization,

as well as resolution to the issues. The performance indicators on this program show that it is positively influencing safety conscious work environment.

Two surveys have been constructed, one in August of 2002 and a second in March, 2003, to determine what kind of safety conscious work environment exists, and the trends of that safety conscious work environment going into little more detail into those late into the presentation.

Finally, the Safety Conscious Work Environment Review Team has been established in the fourth quarter of 2002. This review team reviews all disciplinary activity above a verbal reprimand to ensure that a healthy safety conscious work environment is upheld.

Effectiveness of the actions are measured by quarterly performance indicators that are rolled up to the four pillars seen earlier. These performance indicators show improving trends.

The next slide shows employee concerns contacts versus N.R.C. allegations, and from the year 2003 there is a couple of takeaways from this slide. First, you see that the employee concern contacts is very high. This shows that the employees are using the normal -- the Employee Concerns Program, which shows a high level of trust for that program. You can see there is 157 year-to-date employee concerns contacts and 16 through July N.R.C. allegations.

Does that answer your question?

MS. PEDERSON: It does. It brings up a follow-up question though. Have you looked at this to gain insights as to why people are using the ECP versus the CAP or another mechanism?

MR. VON AHN: The preponderance are management issues. We slice these into mechanical and technical issues, probable HIRD issues and retaliatory issues. The clear preponderance is management issues where there is a problem between management and worker, and these are addressed at various levels. In some

cases, the manager is counseled, some cases it's through HR and other mechanisms.

MS. PEDERSON: For those that may be technical in nature, is there a way in which those things get reviewed in a timely fashion to ensure there is not a safety issue, a technical issue that is being in this program versus being in another program?

MR. VON AHN: Yes, and we would also -- yes, they are reviewed on a timely basis. We would also look at the reviewer to make sure he has the appropriate skill level to review those types of issues.

MS. PEDERSON: Okay.

MR. BEZILLA: These would typically show up in -- like if it's a technical item, that would show up in the corrective action process, if anonymous, if you will, and find out the technical piece of that, and if there is disagreement, we'd have a different professional opinion process we can use to get it raised up even farther, if needed, from a technical

perspective.

MS. PEDERSON: The thing I want to ensure is that if someone utilizes this process for a technical issue that was examined by the right kind of people and the right time frame to ensure it didn't linger out there in a different process, the ECP process.

MR. MYERS: We go over each one of these with the -- we go over each one of those in the report ourselves monthly, so if there is nothing lingering around by the end of that session, we have a good idea what we have, you know.

MS. PEDERSON: But if somebody raises an operability issue through the CAP, you wouldn't want to wait for a monthly report.

MR. VON AHN: If there's a safety issue we would address it through the corrective action program anonymously, rate the technical issue, but not obviously compromise the individual confidentiality.

MR. GUDGER: What Fred is saying, the investigator will issue a report and separate the

two issues, but the technical goes into the technical corrective action program.

MS. PEDERSON: Thank you.

MR. PHILLIPS: You are monitoring this program for trends?

MR. VON AHN: Correct.

MR. GRANT: Along those lines, any time you give a bar chart like that, you do some trending. It looks like it's trended to ECP I read. If it's trending down over the year, and how do you -- how do you assure yourselves that that is -- that that is positive as opposed to people giving up on the program and just not coming to it anymore?

MR. VON AHN: In general what we do is go back to the individuals and do a post survey with them, and try get the information back, was the ECP helpful, did it answer your concerns, were your concerns addressed? And in general we have had positive comments when we have gotten those surveys, post-usage surveys returned. There is no -- we have asked the question, is there other

ECP data out there to benchmark against, see how we are doing, and that is not something that is out there in the industry.

MR. MYERS: There is about four questions about how effective this is, how you trust it and everything else, so because of the threshold, because of the numbers being low, a lot of people feel --

MR. GRANT: And you feel you are getting feedback that says that they trust the program, they believe it's worthwhile in lowering numbers in this regard?

MR. VON AHN: We feel the lower numbers are positive. We also feel because of the positive feedback, the workers will go to a co-worker and say, hey, use the Employee Concerns Program if you have a concern, if you feel that that methodology is a good, you know -- by the positive feedback for others to use.

MR. GRANT: Thanks, Fred.

MR. GROBE: Fred, do you have a sense for how this performance of the Employee Concerns

Program compares with your prior ombudsman program?

MR. VON AHN; There was less trust, especially for confidentiality in the ombudsman program, and there is trust of the confidentiality of this program than an independent investigation, and also the folks get feedback upon resolution of this issue, so I think this is a better program from all those aspects.

MR. GROBE: Do you have a sense of the ombudsman program of the number of contacts per year?

MR. VON AHN: It was less. I don't know the exact numbers, but I know they were less.

MR. MYERS: At one time the number of N.R.C. allegations was much higher than our contacts. That is completely flipped around, and if you go look right now and you ask people about the quality of the program and the survey results, it's over 95 percent of the people would not hesitate to use that program if they wanted

to. That is what I'm really pleased about more than anything else is that a year ago they would go to their supervisor, but would not go to the managers, today they would go to the managers or supervisors in over 95 percent confidence level, so we are real pleased with that.

MR. GROBE: Thank you.

MR. VON AHN: Next I'd like to go into the March, 2003 safety conscious work environment results. There was significant improvement over the results of the 2002 survey, we generally saw improvement in the categories. However, there is continuing need for site-wide improvement in management espousal of basic principles in dealing with workers. These principles are designed to help focus on issues and resolutions rather than people and personalities. They are posted throughout the site. These need to be reinforced. There was also indication of continuing need for management to reinforce safety over cost and schedule.

Continuing on to the next slide,

there was the need for rigorous follow-through on Corrective Action Program improvements. It was acknowledged that the Corrective Action Program changes had occurred, but there was need for follow-through indicated.

There was -- there was also continuing opportunities for site-wide management of safety conscious work environment with contractors. Contractor responses in general were more negative, specifically in the retaliatory and HIRD questions, and we will go into the slide. There is a slide later that shows that, and we will go into that a little more.

The survey also showed pockets in plant engineering, radiation protection and chemistry and maintenance with a higher negative response rate. This concerned us, so we did follow-up pointed surveys with our employee concerns manager to these areas specifically, as well as the contractors issue to find out what that was telling us.

MS. PEDERSON: Will you be telling us what you are doing in response to those?

MR. VON AHN: Yeah, I could tell you right now. Specifically the issues in radiation protection and chemistry and plant engineering had to do with leadership in place, as well as in the case of plant engineering, the lack of leadership. That has since been stabilized, and, in fact, when the follow-up surveys were done, there had been a change out in leadership and radiation protection, and was pretty much an immediate turn-around. And that was fed into the follow-up survey, so the follow-up survey showed that there was adequate action taken already with leadership changes to correct the problem.

MS. PEDERSON: How about contractors?

MR. VON AHN: The contractors -- and I'm going to go into that on the next slide a little bit. I'd like to go to the next slide, which actually shows 2002 and 2003 comparison of survey results, and these have to do with the negative responses to the retaliation questions and the

HIRD, which is harassment, intimidation, retaliation and discrimination behaviors.

You can see that in Questions 7, 30 and 36, the contractors' responses were more negative in the 2003 survey than in the 2002 survey. Follow-up -- again, follow-up pointed questions were asked, follow-up surveys were done of the contractors to find out what was going on here, because it did trouble us, and there was some questions by the contractors on what the question meant, that is -- in their mind it meant had anybody ever been subjected in the last month to HIRD activity, and this meant at other sites as well as the Davis-Besse site.

The contractors indicated that there was that question, or showed some confusion in that area, and our follow up question showed that there were not 50.7 issues, but more issues of management-worker relationships.

MR. THOMAS: Can we go back to -- you mentioned corrective actions for -- to improve rad protection performance was change out of --

put in place new managers, senior manager level individuals, and one individual in particular that I think you are referring to was an inactive position and not going to be there permanently. I was wondering if the other individuals that you put in place are sufficient to maintain improvement performance in that area, or when that individual leaves, will the performance start to decline?

MR. LEIDICH: I can address that. The individual you are referring do is really a new hire from several months ago, that was our -- really a corporate RP manager, RP programs perspective, so his overall assignment, we were in the process of recruiting for that position outside the company for an RP manager for Davis-Besse. But his follow-up assignment would be a corporate oversight for RP across all three of our stations, so even though he is performing in a function now at Davis-Besse, when his replacement is named he will be performing in a broad spectrum across all three plants, so he is

not going to let go of that overall responsibility when that occurs though. That is our game plan in terms of that job.

MR. VON AHN: And obviously we will continue to monitor and see if there is -- next slide. Activities leading to --

MS. JARRIEL: Before you go on, this is Lisa Jarriel again. The two HIRD questions that you explained were not well understood you believe by the contractors answering them. What do you plan to do for your October/November survey with those two questions?

MR. VON AHN: We will clarify the questions to make sure that is understood or get the responses that are particular to the Davis-Besse station.

MS. JARRIEL: You will ask the questions but in a more clarifying manner?

MR. VON AHN: That is correct.

Next, activities -- are there any other questions on that particular slide?

(No response.)

MR. VON AHN: Next is activities leading to Mode 4 as they relate to safety culture and safety conscious work environment. First, operations leadership. Operations leadership has made headway in terms of leading the station in safety culture in activities leading up to Mode 4. We see this is QA mode, operability evaluations and restart readiness, supporting groups, engineering, maintenance. Other groups have had a positive contribution to support of pre Mode 4 activities.

However, station safety culture in some areas has some improvement to be made. Positives seen were the restart oversight plan, management oversight of critical activities. However, areas for improvement were managers challenging one another, specifically in the morning condition report categorization meeting, managers tend not to challenge one another. They will come prepared on their condition reports, but not challenge each other, probe into condition reports, categorization of other areas.

And in initial restart readiness meetings we saw a little -- or we would have liked to have seen more challenging between the managers in other areas than their own.

Next slide, please. Next is Mode 4 execution. What I'd like to talk about in the upcoming slide is our measurement model, the observations during Mode 3 -- Mode 4/3 and final conclusions. The next slide, please.

This slide depicts the model used during the execution of the seven-day normal operating pressure, normal operating temperature testing. The overall concept here was to have a series of checks and balances, so that data was obtained from various sources so we could get a balanced view of the station's performance.

Working briefly in the model, if you go to the center, the center shows the plant's staff, the plant's staff responsibility to the safe, conservative plant operation, management oversight of the plant staff was expected during the evolution, as well as

exterior line assessment of both plant management and plant staff.

Overseeing plant staff activity is independent internal oversight, quality assurance, looking at plant staff activities, and then finally looking down below in the box, external operational assessment. External operational assessment was to look at both quality assurance and the plant staff to assure that root cause issues had been addressed or looked for deficiencies in either of those areas.

The products from each of these activities is a report that will be funneled into a final readiness report, and these final reports are being drafted at this time. Next slide, please.

With regard to Mode 4/3 observations, external observations were conducted by senior executives from various stations, most have previous senior reactor operator licenses. External observations generally lined up with oversight observations,

and I will actually cover these in tandem since they are the same type of observations. External operations also noted one area for improvement in quality assurance, which I'm going to address. It addressed the familiarity of the quality assurance individuals with the folks that are overseeing because of previous activities, and we are going to look at rotations within quality to address that issue.

On the positive, what was seen is rapid elevation of issues related to safety, to appropriate levels of management to address. Also seen was the ability of the shift managers to challenge and push back to senior managers when needed. Additionally, a positive was needed on the suspension of heat-up activities when the potential for plant equipment problems to challenge safety was seen.

Additionally, recognition of the opportunity to use decision processes was a positive. However, there was a downside to this demonstration. There was a demonstrated

unfamiliarity with the use of the problem-solving process. Quality assurance would not have expected to be on a learning curve for this activity and would have expected that the problem-solving process would have been well in hand since it had been in place for about a year.

Additionally, standards needs improvement, standards in the way of three-way communication, use of the phonetic alphabet, and procedural issues were at a level of detail and procedure needs to be improved, all of these standards need to be improved.

And you ask, how does standards relate to safety conscious work environment or safety culture. Standards are the key, they are a leading indicator, if you will. If the standards start to break down, that safety culture safety conscious work environment could be soon to follow. So there is improvement needed in the standard.

Additionally, the ability of operations to look ahead and anticipate

operational challenges was inconsistent. This was seen both with the core flood issue, as well as a myriad or significant number of other issues, more than we would have expected for this activity.

With regard to internal management. The assessment by external management and quality assurance is that the internal management self-criticality needs improvement. The management observations were not critical enough from the internal management. External observations were significantly more critical, so that needs improvement.

MR. THOMAS: Can you help me understand what you are hoping to see, or the product of what the internal management is?

MR. VON AHN: We were expecting to see significantly more condition reports generated as a result of management observations. We were expecting to see more unsats as a result with coaching opportunities, and we didn't see as much of that as we did with the external observations.

The external observations were more critical, and that will go to some of the conclusions I will talk to you about, or some of the recommendations we have made to station management about what they need to do to take care of that activity.

MR. THOMAS: That was going to be another question, so you say you are going to cover that?

MR. VON AHN: That will be in the next slide.

These are the types of observations we saw during Mode 4 testing. Our conclusions based on this were that in general the station demonstrated improving safety culture in pre Mode 4 activities. With regard to Mode 4 activities from a safety culture standpoint, quality assurance observed vigilance in elevating emergent issues to the appropriate level of management. The organization stopped to address emerging issues with potential to have safety impact, and the -- however, quality assurance also observed that the organizational address of issues can be improved.

The station uses the troubleshooting procedure, but it needs -- the addressing of those procedures needs to be improved somewhat in timeliness, and actually, continuing along with the extent of condition and the total evaluation of the issue, there can be some improvement there.

With regard to safety culture and safety conscious work environment, there will be a follow-up survey, but we have seen improvement in safety culture and safety conscious work environment, both by our performance indicators and by the surveys given to the station. The recommendations that oversight has provided to the station are as a result of the deficiencies we have seen in the Mode 4 activities. Those recommendations are to strengthen some aspects of operational training, to improve management observation skills, to implement the fleet-wide condition report trending program and to augment plant staff with external observers to act as coaching mentors to improve the criticality or

self-criticality of the internal management staff.

MR. THOMAS: Will that be documented in the final report?

MR. VON AHN: They will be documented as part of our final ratings, and the appropriate corrective action process will be used.

MS. LIPA: You talked about another survey in safety conscious work environment.

MR. VON AHN: Correct.

MS. LIPA: Is that plan sufficient for restart, factoring in results for the assessment for restart?

MR. VON AHN: We are looking at that, and if it's not, we will adjust the schedule, because that needs to be done.

MS. LIPA: Thank you.

MR. VON AHN: Other questions?

MR. RUETER: On the radiation protection management -- I'm Jack Rueter, I work for radiation protection. Seeing how that is my boss' boss' boss, I work in radiation protection.

The other radiation protection managers that are not currently there, they led to a bit of confusion and not proper leadership. The current person we have now does provide very good leadership and management. He has in place two superintendents, one over RP manager operations and over the ALARA people that plan to stay, so that will provide some continuity when we get another manager in place. So I'm confident that when we do get another manager in place, we will fit in, or as Mr. von Ahn said, the indicator will indicate that management needs to correct the situation.

MR. VON AHN: Thanks, Jack.

MR. MYERS: Okay. Mark?

MR. BEZILLA: Thanks. Next slide, please.

What I'd like to address is the safety culture remaining actions for restart, and they are as follows: First we need to complete our 50.9 completeness and accuracy of information training for all of the Davis-Besse employees, and we are doing training to ensure the people

understand the importance of writing to you all with complete and accurate information and to ensure that they understand the importance of making sure our records and documents are complete and accurate, whether that is logs, rounds and readings, corrective action documentation.

The second thing is we are going to complete an assessment of our calculations program. What we did was we contracted Sargent and Lundy to perform an assessment and provide us with recommendations to strengthen the program, and they will do calculations. They also benchmarked us against Exelon, and I believe they are going to provide us with those conclusions and recommendations tomorrow, I think is when we are supposed to get that report. I think an advance copy already went to my boss, but --

MR. MYERS: I got an advance copy.

MR. BEZILLA: I know that is soon to be in our grasp. The third thing is that we are going to strengthen our corrective action process, and

the first piece of that is -- what we are going to do is provide condition report evaluators with apparent cause training, and the purpose of this training is to reinforce our expectations of them in regard to their efforts and conducting apparent cause evaluations, and that being their investigation is of sufficient depth to invite identification of event specifics and those probable cause associates causal factors, related industry and safe operating experience in an evaluation of generic implications.

The corrective actions developed address identified cause or all causes and corrective actions developed don't necessarily guarantee events or conditions will not recur, but it may be expected to reduce the risk associated with recurrence. So we want to make sure we have a clearer picture of what we are looking for from an apparent cause evaluation standpoint, so we are going to go and give them specific training.

And then the second piece from a

corrective action program strengthening is that we are going to put a group together to review apparent causes, and this review group is going to consist of a number of our condition reports analysts, these are our sort of technical experts, and their focus is going to be content and quality of the apparent cause evaluations. And then we will have that group provide feedback to the condition report evaluators to help us get consistency in our content and our quality, and -- in regard to apparent causes.

MR. THOMAS: Mark, let me clarify a previous question that I asked about qualifications of the individuals doing root cause analysis. I was more interested in the apparent cause level, I wasn't real clear about that as far as that, has that been a factor in the quality of how the apparent cause --

MR. MYERS: Absolutely.

MR. THOMAS: That was more my question.

MR. MYERS: And we've also got to limit that population, of course we've got plans there.

MR. THOMAS: Okay.

MR. BEZILLA: Okay. The next slide. That fourth thing is that we are going to conduct alignment and team work sessions with all of the Davis-Besse employees, and what we did was we contracted with a firm called Ed Ventures, and this firm, in conjunction with the Senior Leadership Team at Davis-Besse create learning maps, and I will show you that in a minute if we have time to do that.

The purpose of the sessions with our folks is to focus the organization on the future and the key role everyone must play to guarantee Davis-Besse has made plans and can move safely to the desired outcome of the sessions to gauge our progress on establishing a number of identifying programs toward nuclear safety, understand and align with our FENOC vision and strategic objectives and roles the departments play in helping to achieve them, to understand that we must rethink how we do business and model others at top fleet performance, to understand

how top fleet performance does not diverge from safety performance, to identify barriers to top fleet performance, to discover how what we do every day directly impacts the success of our station and our fleet, to recognize and appreciate completion of key milestones over the past 18 months at Davis-Besse and within FENOC, to individually complete and hold ourselves accountable for making the required behavioral changes to prevent going back to the way things were and to recognize that this day, meaning the day of the session, is just the first step on the journey. Okay.

These sessions are going to be the start of what we are calling a new beginning, and these session we believe will raise our awareness, and that it's now up to us to demonstrate through our attitudes and behaviors that we are to operate Davis-Besse safely and to assure the health and safety of the public.

MR. MYERS: Let me comment on that, please. We don't find too many things we are excited

about. We think this is unique and new, but we brought up after the report, and some of the safety culture assessment we did. Alignment of the organization went forward, and the things we have to do in the next couple of years, we are going to start up a little larger backlog than we had before. We have got a lot of things to get done in the next couple of years, we've got to do this effectively and efficiently, and primarily safely.

And that being said, we -- one of the comments we have got out of the Haber report is make sure your organization understands it's -- the future is not what it looks like. We brought this team in to work our and they showed us this product, and Senior Leadership Team, and we were so excited about it, we didn't want to quit, it was really exciting, some of the things that we went through and to figure out ways to improve the delivery processes and everything else, so, you know, we think this is going to be a good tool for the employees, and of all the

things we have done, I'm really excited about this program. I invite you to come and watch.

MR. BEZILLA: Jack and Jim, bear with us two minutes.

MR. CALDWELL: What is the name of the company --

MS. BEZILLA: We contracted with Ed Ventures, E-D Ventures, like adventures, like Educational Ventures is what I think it's short for, and then these are the products. Randy, you've got to speak loudly.

MR. FAST: Let me spend a couple of minutes. This is not a vision map, what this is is a map of current reality that brings groups together in groups of about eight to ten facilitating sessions, and there were cue cards and reading for each of the participants, and they come from all over the organization. We have trialed this four different times in the development of this product, but what it does is it really leads the people through a clearer understanding of what current reality is.

This is modeled after the Nuclear Energy Institute model for how to operate a plant, the configuration management, work management, equipment reliability and the support functions necessary for safe, reliable operations.

So what we do is, we -- a lot of people at the plant take for granted, well, I'm in my area, but I really don't know how I interface or reactor responds to others, so there is a lot of dialogue, conversation actually amongst the participants that talks about who delivers products to me, who I deliver products to and what is the outcome.

So we talk about our current performance and the processes that we use to operate the plant. And that sets a standard at least for people to understand the way we operate a nuclear power plant. Let me go to the next one.

These are a little different, I have 20, 25 sets of these in production, and we

will start this on the 12th of this month to roll out. We have seven scheduled sessions. Now, what you will notice here is that on the overlay is the NEI process. But what it says is to start a new beginning, exploring our future. So these are the first steps in a journey moving forward. This talks about FENOC vision is people with a strong safety focus delivering top fleet operating performance. These are the elements of success that will take our plant forward, our company forward, because this is a FENOC process, so it's one that we are not only using at Davis-Besse, but one that we will use fleet wide in developing really the right standards of operation. This has the values that are developed by our company that talk about what we are all about, what we stand for.

We talk a lot about stakeholders, and then the stakeholder analysis and evaluation. We benchmark against standards that the industry has, what are the expectations. Certainly the Nuclear Regulatory Commission is a stakeholder,

you are in on this, we have cards and we talk about that. What are your expectations of us to safeguard the health and safety of the public.

The last, we have behavioral changes going to, hey, I just work in my own little world, I don't work with others to work as a team. So there were behavior changes, so this is a self-revealing process, and I can tell you that I'm excited about it because I saw what I will say are individual transformational changes, not to mention, certainly I wouldn't talk about individuals, but we had one individual, probably the biggest nay sayer came in, hands folded, didn't want to participate, sat on the side, and we said we are going to proceed on, we are going to figure out what's going on here.

The individual was drawn into the process, and by the end of the process, which takes -- this is an eight-hour session -- actual maps take about 90 minutes apiece, and there are some other elements, but by the end the individual was so enthusiastic, he was clearly

sitting in the middle of the group and became the natural leader and kind of the rah rah and the charge forward, so it's kind of an exciting process.

And so again, not vision maps, these are learning maps, they become self-revealing, and understanding what it takes to operate properly, and then what our standards and expectations are, what our vision is and what it's going to take to accomplish that vision. So we are excited about it, and I think it's going to be an excellent tool in kind of then aligning our folks, we call it alignment and team work session. It's team work, because as we have put these groups together -- I watched four sessions -- I saw people that had not worked together in records management, I'm in operations, I'm an engineer over in configuration, in design engineering, those groups then actually bonded together to form that alliance, and part of the product, the result of that is actually an affirmation by the individuals and the team

members, and I actually saw that process where somebody said, hey, I have a problem with the procedure, call me, I can get the procedure, whatever you need, and so we saw that kind of team building that was going on during this process. So we are excited, we would invite you as well to come and observe the process.

MR. BEZILLA: Randy, what about the safety culture? I thought there was like surveys.

MR. FAST: There sure is. This process is that when we have the alignment and the -- understanding the next steps that we go through, which I don't have the maps for because they are really not maps, but it's a, let's go back to basics about what is the safety culture, what is the model, what is the definition, how do we gauge safety culture and so we are going to have an interactive dialogue amongst these teams, and then there is a product that is delivered from that, and that is the -- each individual then can actually make their own proclamation about where do I believe the management and individual

contribution to safety culture is and rate that anonymously, and then take it down, I work in the maintenance department or I work in operations, I work in engineering, and then we will direct that, so we are going to get about 800 plus pieces of data, which then we will dissect, evaluate and roll out to the managers, because really that is coming from our work force that said, here is where we think we are, and they can write suggestions, comments down and see if they think that we are not talking the talk, we were not demonstrating the basic contributions, they can write that down, and that's okay, we want that feedback, we need that feedback, that will really help us to perform a better assessment for Mode 2.

MR. PHILLIPS: Did I understand you to say the groups that are involved in this whatever you want to call it, training session, are selectively picked to have cross departmental --

MR. FAST: Yes, sir, yeah, I wouldn't -- we won't have two mechanics sitting next to each

other, we are going to have --

MR. PHILLIPS: Mechanics?

MR. FAST: They are assigned to a table, the table has a facilitator, we've got about 30 to 35 facilitators, they start training on Monday, so I'm excited about that part as well.

MR. MYERS: This is an interactive process, I can assure you.

MR. FAST: It's very interactive, it's based on conversations, and you think about what changes culture, what changes culture is what is talked about at the water cooler, it's communications, conversation between employees, that is what drives organizations, and this creates the opportunity for conversation.

MR. BEZILLA: Thank you. Thank you, guys.

Two more of the five items, to identify and reflect and act on the lessons learned from the recent normal operating pressure test. We will address plant people and process issues throughout the normal operating pressure test period we have identified through

observation, data base and your corrective action process.

Opportunities for improvement, Frank talked about the internal management observations, the quality observations as well as the external observations, we will also have that product, which is currently being drafted up, and it will be finalized I suspect in the next week or so. And what we will do then is we will capture all those opportunities for improvement, and then we will address those issues as appropriate prior to restart.

So the operating pressure test before gave us a real good opportunity to check out the plant, check out our people, check out our processes. I think we have like 80 observations over that period for management, we have got a Q.A. observation, we have got external observations as well as self-revealing events that we have captured, either in the observation process and/or corrective action, observation data base or corrective action process, so we

think we have got a real good pool of information to figure out what we want to do between now and restart from a plant people and process standpoint.

And then the last thing from a safety culture readiness for restart standpoint is we will, when appropriate, conduct restart readiness reviews, and I will say this is our final assessment and checks of our plants, other people and processes readiness for restart.

And that review process also includes a review and recommendation for restart from our Station Review Board, which is our internal safety and operational review group, our Company Nuclear Review Board, which Lou talked about earlier. That is our external safety operational review group, and then our Restart Oversight Panel, which is an external group we put together here to monitor performance through this outage period and through the restart effort.

So these are the items from a

safety culture perspective that we feel need to be completed prior to restart. If there are no questions, I will turn it over to Gary.

MR. GROBE: Gary, it may be time to stop for another break. You've got several slides here, and then we go into the presentation by Randy. I'm not sure, I will leave it up to you as to when you want to break, I'm not sure if it makes sense to break now.

MR. LEIDICH: I think we can do that because really we are going to go to having said all that, where are we going long-term, so this is a suitable time.

MR. GROBE: Great. Let me make a couple of observations before we break. We have several public meetings next week. On Tuesday there is an afternoon business meeting with First Energy, which will be conducted at Camp Perry. The significant focus of that meeting is going to be on the results of the normal operating pressure test, both from a standpoint of the results of the test itself, leakage results of the test

itself as well as other recommendations that came from that, and we are going to get into great detail in that meeting on the normal operating pressure test.

And then a public meeting in the evening, meetings with the public in the evening, and then the following day we have public meetings at the Davis-Besse administration building on-site to discuss the results of two recent inspections, and we have kind of touched on those issues throughout the first part of this presentation.

Those two inspections, one covers the corrective action program effectiveness and the other one has to do with systems readiness for restart. So we will have that public dialogue and the result of those inspections Wednesday morning at the Davis-Besse administration building. So those are two meetings where we are going to get into a lot more detail -- or actually three meetings where we will get into a lot more detail on some of the

issues we barely touched on during this presentation.

So why don't we take a ten-minute break and be ready to go at ten to 4:00.

(Whereupon, a recess was had, after which the meeting was resumed as follows:)

MR. LEIDICH: We'd like to shift to longer term focus, a couple of pieces of that, and the piece I'd like to cover is really from a corporate perspective, and as has already been alluded to we have a revised vision for the First Energy Nuclear Operating Company.

The Executive Leadership Team met at the end of June in an off-site meeting to work through that vision, and that vision is on Slide 63, as can you see, people with a strong safety focus delivering top fleet operating performance.

There are several messages in there. Of course, first and foremost is people, but the strong safety focus is integral to our

vision going forward. It's about delivery, it's not about efforts, it's about results. It's about top performance from an operational perspective, and it's about the fleet -- taking a fleet-wide view in everything we do. So that vision was carefully structured over that two-day period with the process of rolling that out. So as you visit the stations, you will see the signage accordingly. Page 64 talks about our approach, and our approach is really a very simple template.

Given that vision, we have developed five strategic objective areas, safe plant operation, people development and effectiveness, excellent material condition, improved outage performance, fleet efficiency and effectiveness.

At this stage we have developed 18 performance metrics. In those five areas, working our way through those goals and metrics, and definitions of this period of time, and what you will see is really an integrated approach to

accomplish a vision across the fleet and all three stations, in the corporate office and through the teams and metrics across the entire organization.

If you saw Randy's map, that is really an integral part of what we are rolling out at Davis-Besse, and really in the process of doing that across the fleet, what it really looks like from an organizational effectiveness perspective is really identified on Slide 65, and these are the things that we keep an eye on.

First of all we have got trust. In our work force, we've got leaders that are trusted by the employees. You know, 90 percent of what we do is just communications, so if you are into a vision, you understand standing in a different place, if you will, the way to effect that is through open communication, and what you say, what you do to listen. We have demonstrated respect for each other, we have a team to evaluate feedback and input, have we got good accountability, team work across the

organization, of course, with the safety conscious work environment. Do we have a willingness to go up here and address problems, and are we involved, is management involved in activities and decisions.

And I think across the fleet we have got a renewed interest and high level of involvement with daily telephone calls. From an operational standpoint we are actively engaged as executives in running this fleet.

And one of the things that we are doing going forward is we are transitioning to a corporate organization, and one of the jobs that we recently announced is an organizational effectiveness director. And that individual is Randy Fast. And, of course, Randy has been actively engaging in the Davis-Besse culture change, if you will, and his assignment is to finish that work at Davis-Besse and then take that work and approach that on a fleet-wide basis to ensure that we have got long-term, solid staying power with what we are doing across the

fleet.

So I'm going to turn it over to Randy, and he is going to talk about the actions that he's up to, not only at Davis-Besse, but across the entire organization. So, Randy?

MR. FAST: Thank you, Gary. First, I'd like to say I'm excited about this opportunity for me personally, and working with each of our stations.

I'd like to spend a few moments to review the actions that we have taken, First Energy Nuclear Operating Company, to anchor long-term improvement. Anchor is an interesting word, isn't it, that I kind of learned. Lou used to talk about hooks and procedures or places where you have point of connection. The anchor is a term that we are using in 50.9. I went and looked at all of our documentation in preparation for this, is it backed by procedure, by policy, by a practice that is institutionalized in the way that we are going to do our business, and can I give you my personal assurance we have got a

machine here that we put together that is -- it's up to Lew, things like 4-Cs meetings, it's not just something that Lew espouses and participates in, but it is a business practice, so it's institutionalized and it's anchored.

The first thing I was going to talk about, just reiteration, but our new officers at the corporate level, Gary, Lew, Joe, Mark, Fred, are all examples of an organization that is built to last. So a lot of things that we have done in the improvements are in the plant systems.

Davis-Besse is an older station, and some of the lessons that we have learned we are sharing with the industry, but the containment sump improvements that we have made here, the containment air-coolers, boron precipitation, high pressure injection recirculation, the things that we talked about, we were the first domestic company in the United States to have a leak detection and monitoring system, a diesel air start, as well as programs.

So those are -- material discussions continue, but we have what I think are industry-leading boric acid corrosion control program, operating experience program we use internally and externally, and the fleet detection and latent issue programs that are institutionalized, proceduralized for Davis-Besse and for First Energy Nuclear Operating Company. The next slide please.

Improvements in personnel performance, just a laundry list, just get some of the highlights back in the case study, there was a bit of a water shed and really defining clearly what were the conditions. We provided individuals clarity and understanding of what led to that event, and so that we were able to then capture the attention of our folks, and then that built a framework then going forward.

New training for managers and supervisors on nuclear safety focus and professionalism, that is institutional identification in our leadership or action

programming that the development of our new supervisors, but as well as in our what was called ownership for excellence transition is part of the First Energy process in performance management.

Department level expectations across the board that really demonstrate what our standards and our expectations are, so every organization that is there has documented the standards and expectations for the department and employee performance.

Improvements in communications and teamwork, 4-Cs, the all-hands meetings, all examples of where we are trying to communicate with our folks the alignment of our management personnel. Lew talked about the executive leadership team and getting together and forging a new future as well as the Senior Leadership Team has gotten together, really talked through roles and responsibilities, actions that we are going to take going forward, we have extended that to our managers and talked about the

learning maps, extending that on to all of our personnel.

The improvements in personnel evaluations, I talked about that ownership for excellence, that really was developed as part of our First Energy Talent Management Group, leadership development using the RHR, really that close scrutiny in our personnel performance and understanding what things we need to do to have what RHR calls the right stuff.

Our operations leadership plan started with just turnover process, where, when, what are we going to talk about, who are we going to involve, and then it permeates the whole organization. We talked about the new employee orientation manual, but that's why we institutionalized the new employee orientation manual, because that's a challenge for the folks that have lived through this. We have a pretty good understanding about what's transpired, but what about that new employee, that new engineer, that new non-licensed operator, that new

instrumentation control technician, they need to understand what our standards and expectations are, so that is institutionalized, our new employee orientation manual. The next slide, please.

Program reviews and benchmarking, and I just can't say enough about the corporate oversight, and as I have had several days experience in Akron working with the folks there, they focused on industry best performance and then bring it to the fleet.

Corrective action program improvements, we have talked about our employee concerns program, and I do believe as well from my discussions with employees that there is a great understanding and a belief that the Employee Concerns Program will bring them relief to the questions and concerns that they have.

Our operating experience program, radiation protection program, Jack talked about that. We really -- we know the procedures and we have some -- we have state-of-the-art equipment

in the organization, so that has created alignment and high standards going forward.

Boric acid corrosion control and leak detection, I believe that these are industry best, one of the -- one I will say foundational thing that was done which really built teamwork and alignment from operations and support organizations, principally engineering was our operability evaluations, and we did two days training on that. I participated, the other directors at the site, managers, and key individuals. We had over 100 people that went through that training, but really a team approach to solving problems, and we know based on regulatory feedback that operability evaluations were -- they needed a lot of room for improvement.

We have not arrived, but we are continuing to grow, and we are working on that as a team. Many examples, we have talked about the problem-solving and decision-making. Next slide, please.

MR. THOMAS: Randy, on the slide prior, you had talked about operations leadership, and I was wondering if you, or not necessarily you, but any member of FENOC can have an assessment to the degree which they believe that operations has assumed that leadership role?

MR. LEWIS: Art Lewis, shift manager of operations. Mike Router has put out a document not very long ago that listed numerous instances where shift managers have had to stop work because everybody is trying to get a job done, get the plant on line. Operations, as illustrated in a couple of the slides, has elevated the review. SRO operability for condition reports, operations has stepped forward and the equipment operators auxiliary operators have just said -- I asked my crew if we couldn't deal with a concern that you have as an employee, what would you do with it? He said we'd bring it to you. What if I can't resolve of it? They will take it up a notch to the superintendent or operations manager. And I said, if you can't get

resolution there, what do you do with it? Employee Concerns Program. So even the lowest denominator to very important person still has stepped forward and is trying to lead the facility and step it up a notch to meet the requirements, and that is required of us.

MR. THOMAS: And when they do that, what type of response do they get from the organization? Is the organization receptive to those concerns, or --

MR. LEWIS: Very much so. There was a concern about a leaky pipe, he submitted a condition report, brought that to a shift manager, shift manager elevated it and engineering walked out in the plant with an equipment operator that identified it, it was a design engineer. To make a long story shorter, isolated the system, cut the pipe out. It was nearly plugged, corroded with corrosion products, it was because of that and the engineering involvement that made that system successful again. Quite a bit -- 200 feet of pipe got

replaced. Other EOs have told me about engineering getting involved, coming out to seek understanding on condition reports that they have submitted, and that interaction is getting more and more predominant, and everybody's learning curve increases.

MR. THOMAS: Okay.

MR. GUDGER: I will add to that, in regulatory affairs we see the shifting down and making assignments to the staff engineer, as well as the regulatory affairs for past operability issues or issues that they want followed up, and they put time clocks on those, we are seeing a much greater increase in that activity, and in my organization in the plant. So we are real pleased to see that, because that leadership role really does define the marching orders for the rest of the plant involved, and they understand the priority and importance when we get a phone call, and that hasn't always been the case.

MR. THOMAS: Okay. Thank you.

MR. MYERS: You were the senior resident,

and you know there was a lot of things that we fixed during that outage that weren't restart items, you know, we -- the diesels, they are going to be leak free. We have added -- we have put air dryers in the diesels, that's been a long-term problem. Reactor cavity, which was not a restart item, but it was the right thing to do, you know, and we should have put that in years ago, so, you know, I think that message is that we are going to maintain our plant, not as quo for 1970, but we have got to have a process in place so we can find and fix problems, and not justify the problems.

And I think we have demonstrated that over and over again, and I think people can see that.

MR. THOMAS: I don't disagree that you have made a number of improvements to the facility, but what I was trying to say is that -- to get your opinion about is to what degree do you think ops has assumed the role of leadership of the facility?

MR. MYERS: I think what I was trying to say, though, is if you go fix the problem, they will assume the role. It's when you beat them into the ground so they lose confidence in management that they lose that role. You know, we've got to find and fix the problem and take them seriously, and I hope that -- our belief is they are addressing that because they know that I take it seriously.

I don't expect to walk in the control room and find a recorder is not working, I don't expect it, you know, so --

MR. FAST: Okay. Slide 70, please.

MR. LEWIS: Again, I have got a document that -- I will get it out -- I didn't bring it to this meeting, I didn't get it out before I left the plant last night, but this document is called Command Responsibilities dated January 30th. And I didn't do anything special to it to make it look old, I tried to refer to this eight, ten weeks, and it tells me I'm the plant manager's direct representative two-thirds of the time. I

will speak for myself and I will put words in the my peers' mouths, we do take that serious. And when he is not there, I have had numerous instances where we have had to make phone calls to activate the management team, and I have never had anybody turn me down. So I think that is demonstrating a change in the culture. Like Dave said, people listen to us, we activate when we need to and move forward.

MR. MYERS: Once again, I don't think anybody goes out on a limb by himself, we have got 800 people outside, I have got a beeper 24 hours a day, and we always had a duty management team. They need to be able to utilize that team whenever they need to 24/7, and that is the expectation, you know.

MR. FAST: Monitoring and oversight are obviously part of the process to ensure that we continue to go in the right direction. The management observation program has been cited and recently benchmarked by Exelon as leading the industry. Now, we know from a process standpoint

it's good, now we need to be able to bind the results of the observations, and we need to become more critical as they are identified, but a program is in place, and I can tell you if an individual does not perform an observation as scheduled, they get a letter.

Now, that is the outcome, that is just accountability, but that's why we demand participation, and we get good participation, so I believe that is a part of the management intervention and interaction with the employees, that is absolutely critical to success for the future.

We have performance indicators that are located in each of the key areas of the plant, and these shadow boxes are demonstrations of the performance within the individual work group, whether it be design engineering or regulatory affairs or the radiation protection organization. Those are performance indicators that that organization is tracking and trading on a monthly basis, and they are very prominently

displayed.

We talked a lot about our safety culture assessment, and we feel good about that assessment. We feel that that is -- that assessment has been well developed. It's got room for improvement, it's an interactive process, but we believe that we have a process that will work well for demonstrating the future.

Engineer Assessment Board, we have talked about our quality assurance organization improvements we have made that accompany the Nuclear Review Board.

The next slide shows that here's where the rubber meets the road, what are we going to do to ensure that we keep going in the right direction. We have business practices that are in development that do have two key attributes, one is to assess the organization on a regular basis, and the other is that it monitors through a monthly performance indicator the performance of the station.

So those are in development and I

have those actions. We will perform the line organization safety culture assessment prior to Mode 2, use the restart readiness review process. We talked about the Rev 6, we have got some opportunities for improvement, we are working on some new input for the Rev 7, but that is -- that will be done in accordance with the restart readiness review.

The line management safety assessment, we will be doing that every two years, that business practice, so it's something that will be institutionalized going forward.

As Fred had talked about, we are doing a safety conscious work environment survey fourth quarter 2003, looks like November and annually thereafter. Quality assurance also is part of the process to ensure that there is alignment between line management, and then internal independent assessment in the fourth quarter of 2003.

We will do a quality assurance independent assessment, and the model for that

really was one that was developed from Dr. Haber and her team, and we have used it once, and it did provide good feedback and it did show good alignment with the line management assessment, and we will be doing that annually thereafter.

And then lastly, just to make sure that we have an outside perspective, we will go use an outside independent safety culture assessment in the last quarter of 2003. That is our outside consultant using their process, not ours, and then look at our station and determining are we continuing to make the progress in safety culture. That concludes my presentation.

Are there any questions?

MR. GROBE: I have got one, Randy. The second and third bullet on that slide. The line organization safety culture assessment prior to Mode 2 and line safety management, safety assessment every two years, are those the same as --

MR. FAST: Jack, to answer the question,

they are not the same, because the line organization safety culture assessment is part of Davis-Besse business practice. That restart readiness review has three key elements, safety culture assessment, a system health report, and then an organizational affirmation readiness going forward.

So those are the three key elements. The safe line management safety assessment will be a business practice, which is a stand alone for safety culture only, though that's done while we are operating the plant, we will compile the information and then perform the review of the safety culture.

MR. MYERS: That is going to be in all the fleet.

MR. FAST: Right, but it's in Davis-Besse right now.

MR. GROBE: Will it be different in its scope and depth and technique than what is the safety culture piece?

MR. FAST: No, it's the process, it just

does not have the other two elements, does not contain -- now, there is many inputs to safety culture that come from maintenance rules, system health, maintenance backlogs and things like that because those are key indicators of organizational effectiveness, so -- but the elements of the safety culture piece are going to be lifted entirely into a new business practice, which is used in our FENOC stations for doing an assessment every two years.

MR. GROBE: When will the quality assurance and independent assessment fourth quarter of '03, when is that scheduled?

MR. FAST: I have just started some dialogue with the quality assurance manager, and we think that November is approximately the right time to do that, so he's aligning the resources necessary.

MR. GROBE: Okay. And if I understood correctly, there will be a line organization safety culture assessment prior to Mode 4, and then a revisit prior to Mode 3, is that right?

MR. MYERS: That is prior to Mode 2.

MR. GROBE: Thank you, right. When will the business practice to monitor safety culture monthly be available for review?

MR. FAST: I'm committed to have those out by end of year, because they are really going to be in place for 2004. However, I'm working through a plan to get those piloted at our other stations, so I haven't been -- I can show you what I have in draft, Jack, but I would not expect them to actually be assigned business practice. What I would commit to is the end of year.

MR. GROBE: Is there a procedure that Q.A. has for the assessment, is that already in place?

MR. FAST: I don't know if that is a procedure.

MR. VON AHN: There is not a specific procedure. We do that in accordance with the assessment. It will be a focused assessment to that particular attribute.

MR. GROBE: I apologize, I thought I heard

you say that was going to be modeled after some other assessment or something like that.

MR. FAST: The process that was put together by Q.A. has been done one time, took some of the elements that were developed by Dr. Haber in interviews, surveys, monitoring of team meetings, and then worker performance. So those were some of the -- it's not as well defined with what they call BAR and -- behavior or whatever, something, I can't remember the acronym, but it's not as well developed, but it has some of the same attributes.

MR. GROBE: Okay. Any other questions?

MR. HOPKINS: We have a question at headquarters.

MR. PERSENSKY: This is J. The business practice to monitor what you said, they were going to be out by the end of the year, what form are they going to take? Do you have any idea in terms of how would it relate, for instance, to the safety culture assessment as part of the --

MR. FAST: J., it takes some of the key

attributes, most are more objective than subjective, so it takes maintenance rule temporary modifications, operator work arounds, maintenance backlogs, things that are really things that we can create a compilation of indicators that will feed into a monitoring tool, so it's more like an -- so that's why it's called a monitoring tool, it does assess, it just takes key elements, aggregates them, provides a numerical rating, and that numerical rating is discussed as part of the monthly performance review, so that's the process that we use.

Now, what you do is if you saw a decline in trends based on inputs that were, say, growing backlogs or things of that nature, then the management team would take corrective action to get that back in line. So it has some very specific -- but it's more objective than subjective, so it's not an assessment, it's a monitoring tool that aggregates numerous inputs.

MR. PERSENSKY: So more the P.I. level?

MR. FAST: That is correct.

MR. MYERS: That's right.

MR. PERSENSKY: Your Mode 2 safety culture, I heard that the quality assurance, that is going to be done from your interim Q.A. group?

MR. FAST: That is correct.

MR. PERSENSKY: That's all I have right now, thank you.

MR. RULAND: This is Bill Ruland. As far as this business practice monitoring system that you are developing, let me ask you somewhat of a hypothetical question. Let's suppose that you had the circumstances of the hole in the head, you were -- you had that same circumstance happening in the future, what part of this monitoring system would pick that up?

MR. FAST: Well, I will try to provide you something tangible. If you look at engineering backlogs and the modifications, timely implementation of modifications and corrective actions would be, that is something objective which we can look at what are the numbers of modifications that are out there. In the case of

the reactor vessel head, we had proposed a modification to provide viewing ports years previous to the event back -- I think 1990 was the first time. So now, would that individually solve the problem? The answer is no.

However, if you have backlogs of engineering design changes, that can be an element that would feed into this type of event.

MR. RULAND: Thank you.

MS. GOODMAN: This is Claire Goodman. I'd like to confirm, I think I heard you say that the second one, the line organization safety culture assessment, and then the third one, the safety assessment every two years, that the same assessment, or it's just -- you called it safety culture assessment in the second one and safety assessment in the third, but I heard you say it was the same thing.

MR. FAST: Claire, the line organization safety culture assessment Prior to Mode 2 is called a restart readiness review, and it has safety culture as one of three elements in it,

and then the line organization safety culture assessment every two years is only that safety culture portion.

MS. GOODMAN: Okay.

MR. MENDIOLA: This is Tony Mendiola. I want to make sure that of the six items on this page, four of them are continuous, will be continuous items. The first item and the third, fourth and fifth item. The second and sixth item are one-time-only items?

MR. FAST: That is correct.

MR. MENDIOLA: Thank you.

MS. GOODMAN: As a follow-up, No. 6 is a one-time only. Is there any thought to that that might be repeated again if the trend was not going in the right direction or something?

MR. FAST: Claire, I believe if we do not get the results that we would have expected, certainly we would have corrective action, and then the natural outcome would be that we'd have to go back and reassess at some time later.

MR. MYERS: You know, I guess the ACRS, a

long time ago they were talking about a regulatory standpoint, from the N.R.C. standpoint, would -- how would the industry monitor this into the future. So one of the things that we are looking at is the Institute of Power Operations' process, and if that comes about, then we would join the industry, you know, so, you know, is this one time only? I don't know. If it does come about that that is part of their normal observation process of monitoring safety culture, then we would allow ourselves that.

MS. GOODMAN: Thank you.

MR. FAST: With that I will turn it back over to Lew.

MR. MYERS: In conclusion, I'd like to take few moments. I don't intend to cover every one of these slides, Jack, I put them in here for you to sort of look at. Before I showed you the barriers that -- I think to an event challenge. I think there is four barriers that we look at, the individual itself performing, in a quality

manner, the programs and procedures that we have in place. If you go back and look at the issue, every one of these barriers, you know, our procedure was poor, our training on the individual was poor, and I went and looked at each one of them. And then the management itself, of assuring that you have got the right oversight, and then the independent oversight process itself. When those barriers fail, I wind up with a challenge, resulting in an event.

What I did was, I used this before, but I went back into something a little different this time. Under each one of these areas I went back and tried to correlate that with the criteria that feeds the safety culture model, and -- for example, on the individual barrier, if you look, you say what is the criteria? Well, there is four of those -- five of those criteria, drive for excellence, outstanding attitude, questioning attitude, rigorous work control, open communications and nuclear professionalism, that thing sort of fits

that barrier.

Now, in the first one here under individual commitment area we have taken a lot of actions, I told you some of them, evaluate supervisor, provide the head case study, refresher training for the leadership, safety conscious work environment, we covered that, town hall meeting, all-hands meeting. We strengthened the pre-job meeting at our plant, and I believe we have really strengthened the reverse breaches that we have to work on.

We have implemented the operations leadership plan, and then we went back and requalified all our root cause evaluators, and we are going to do some training on a limited number of people in the apparent cause too. If you go look at the next couple of slides, what I did there was I just went back and looked at the attributes that feed each one of the criteria, and so I'm not going to cover that in the individual areas, but, for instance, in the drive for excellence, there is a whole bunch of

attributes.

In the the next one down, under questioning attitude, you know, pre-job briefings, condition recording system, number of programmatic CRs. There is all these attributes, and what I found is that those things, when you look at them, really correlate very well, it was just a different way of looking at this.

And so right now I will go on and skip on to the programs area, program, policy and procedure. If you look at say what have we done there, we have taken, I think, the statement of policy, the management value structure resources issue and criteria, and the oversight would fit that barrier very well.

We have taken a lot of actions there. First Energy Board of Directors passes a resolution, you know, there is a really strong commitment from our board and our Nuclear CEO visited the site several times, the Board of Directors are down there, the Nuclear Committee, the Board has been at the plant. We have

established a policy on safety culture that we didn't have before that enhances the FENOC values, and we think that our last visit was, you know, excellent, and there is a lot of questions about what that means to the safety in our investigation, you know, that is really a strong message, we are concerned about the employees, strengthens our incentive programs to ensure they tie with safety.

We have ensured we've got the right resources, the executives, we have established an independent level of quality assurance, and I think we have greatly, greatly strengthened our Employee Concerns Program and our Safety Conscious Work Environment Policy.

So, once again, I won't cover each and every one of the things that we have completed in the various programs, program areas, but another thing that I think has been extremely powerful for us is the 4-Cs meetings. To me that is a direct way of bypassing it all and getting the questions right to the site CP, and have him

at the end of each meeting look at them in the eyes and say, these are what I understand are my actions, and you follow through on those actions.

And in the management area, we have -- there is four or five of the criteria I think fit that very well, emphasis on safety, clear responsibilities and cohesiveness, acceptance of responsibilities, qualification and training, high organizational commitment and finding and fixing problems.

But we have taken a lot of actions there. We have improved our management technical policy, we demonstrated that in the slides that I showed. The team I think is -- the team is as strong as any in the country. Most of them have advanced degrees, SRO experience, they are quality managers, so I really feel fairly good about the management team.

We strengthened our Corrective Action Review Board, we have established -- we have anchored that Engineering Assessment Board that we had at our other plants that wasn't in

place at the Davis-Besse plant. We have revised our competencies on appraisals, that is a major issue, and we used that first last year, but we now have two new competencies that evaluate each and every professional, new leadership in action, competencies in action are being used.

One of the things we found when we got to Davis-Besse is we have a leadership in action program, walked around the plants, and you see the ways that we are supposed to do business. That's true at Perry, it's true at Davis-Besse, it's true at Beaver Valley. We found that when we got to Davis-Besse that they had had a different vision, and none of that stuff was there, you know, it was like not there. And so, once again, it was like an isolationist corporate organization. We put in place -- my new job was to prevent that from happening so we have made a lot of advances in the management area to ensure something like these vessel head issues don't happen to us again.

Once again, I'm not going to cover

each one of the attributes, I just thought those were interesting to put in the slides. If you go look at independent oversight, you know, we have created new jobs, enhanced the quality assessment organization, we took quality control -- I mean quality control and went back and looked and what we found was that our plants if you had problem in the field, provided you fix the quality control, did not write a CR, so what was the error rate? It wasn't there, you didn't know. And so we've taken quality control and took them out of the line of organization and put them under Fred to get them that independence, and we think that is a really positive move.

The Nuclear Committee on the Board of Directors, you know, Bill Call is now the chairman of that board. Bill comes to us from the South Texas project, he's well known, I think he will require some really high standards. Let me tell you, he's involved with the plant too, because he calls Gary and I every other day, I think, to find out what we are doing and how we

are doing it, gives us a lot of feedback, and he's at the plant.

The Employees Concerns Program is once again under Fred, and I think we made great progress there. The INPO assist visits brought us out of isolationism. We had a visit from the independent team of executives this week that was extremely hard hitting and -- really hard hitting, and next week INPO in our plant again with all the regulatory assessments that we have going on now. But it's going to be good for us, and we have got a really strong team coming to our plant to make sure that they help us with the assessment before we write the report, and we are ready for restart.

Restart oversight plan is independent, at those meetings you can tell those people have got a mind of their own, it's not a group you can control, so -- but they have brought a lot to the plate and are a very experienced team.

And then our safety culture

assessment, you know, we think that this process is a strong process, and I'm excited about it. It's a different management tool, different way of looking at things, but I'm really excited about using that management tool in the plant and in the future, and one -- you know, I have participated with a lot of industry people at other meetings that I know you know about, and I have looked at their progress each and every one of them, but, you know, I think that taking the best of all their processes, and we have got a good correlation, we have got convergence, and the thing I think is more important than anything else is we have alignment ownership of our issues, and we are going to fix those issues.

From the seven-day test, I will move on to that, you know, from the seven-day test we accomplished a lot, took the plant up to normal operating pressure temperature, you know, the plant was leakproof, it really was tight, and better than I'd hoped. As a matter of fact, you know -- and so I was pleased with that. A lot of

the new monitoring and equipment that we fixed, you know, we put the new seals in the tool pumps, they staged well, ran all those, you know, and were pleased with the performance of a lot of equipment.

We did have some issues along the way, we mentioned some of them, breaker spray pumps, and then the auxiliary feedwater pump had been around since 2000. We fixed it and we fixed it because we put our troubleshooting team together, and, you know, I called the shift supervisor one night late and I said, you know we have two hours, if we have to cool down, it's okay, you know, it's okay, we will cool down and we will start up event free and we will come back, because we have learned a lot, and we will just do it better next time, but we will go fix this problem before we start back up.

That being said, you know, we were able to realign the pump, start it before we took the cooling pump off and when we looked at the traces, we could immediately see changes in the

traces of eight linkages, you know.

So I think we really got off that problem, and the troubleshooting team and decision-making team service. If that team had been in place and that approach had been taken and we had the right management ownership, we would not be sitting here today.

Going back and looking at the work activities, you know, there's been several times each work activity was stopped on discovery, you know, we stopped what we were doing, and, you know, when we were heating up, Jack, I talked to you and I mean we made a decision to quit heating up, we made the decision to go back the other way, and we thought about it, we thought there were more risks to that than where we were at, and looked at that in great detail and got management in on it, put our team together and assembled that team and got the right management program, so those are the things that I think have worked well for us in the past seven days.

If you go look, we started the

test September the 21st, we ended it last night at 1600, you know, and by tomorrow sometime or late tonight, we start cooling back down.

But in summary, you know, I'm pleased a lot of the process improvements we have seen, I'm pleased with a lot of the team improvement, and I'm also pleased overall with the involvement of the management team and also the oversight organization, I have been pleased with them, so with that, that's all I have.

Thank you.

MR. LEIDICH: I think just in closing overall, first of all, we appreciate your time today. I think as we got together, we didn't get through all 91 slides, but we -- there is a lot of material here, but we do appreciate the opportunity to present this sort of whole picture safety culture and what we are trying to do across the fleet, particularly at Davis-Besse.

You don't make a cultural change overnight, and we don't come in on Monday morning and say it's a whole new culture. Our

perspective at this point is that we have made tremendous progress, we have got a ways to go, we have got a process system management team in place as far as where it needs to be, and we appreciate your time, Jack.

MR. MYERS: Can I add one thing? We said something in the meeting a while ago, we started the plant back up, we come to you for restart. The message is it's a new beginning, I don't think we would have everything fixed so it's perfect, but I do think that people have a new beginning so that the trends will be right and the ownership and management team will be right to keep us going forward, and we will be built to last.

MR. GROBE: Okay. Any final questions?

MR. PASSEHL: Dave Passehl, project engineer. A little earlier in this meeting you mentioned you were going to be doing your next safety culture assessment in Mode 3 prior to Mode 4 and then and spot-check this Mode 2. Did I misunderstand that? Because your later slide

said were you doing it prior to Mode 2.

MR. MYERS: We will be going by what you said at first. We will be doing a detailed one at Mode 3 and then come back before we start Mode 4, and when we get to Mode 2 and make sure we feel fine going forward. If we see anything limiting, we will turn around and go the other way.

MR. PASSEHL: Okay, thank you.

MR. ZUICHOWICZ: My name is Ray Zuichowicz, I have been at the plant since Day 1, part of the original start-up crew. One thing they didn't mention earlier is -- I'm also the chief steward at the plant, I represent maintenance. The maintenance organization is ready go forward with restart. We've taken ownership of the problems, we have tried to address the situations. You have heard Gary, Mark and Lew talk about the things they put in place. I'm not saying they're all effective, I haven't seen all of them in action, because lot of things we haven't tested yet.

Some of the things I have seen, speaking of the safety culture, the one single thing that comes up in my aspect, from my standpoint we -- I can see are just coming into where we do our most work in this plant, we have the ability from the apprentice to the top journeyman to stop our job at any time that we are uncomfortable with it, if we are not clear on it. We stopped the progress several times during this Mode 4 startup, we stopped the progress of the plant because we had a problem with our job.

And you asked earlier how was that received? It is not always received with open arms when they are trying to do something and there is resistance because there is a problem, but never once have they not resolved the problem. They resolved the problem and there is a culture change taking place. It's not an overnight process and there is still people that are uncomfortable with it, but it is there and there is nobody that I represent in my organization that hestitated at bringing forth

the problem and also does not have the ability to stop the job when it becomes necessary. I just wanted to bring that up.

MR. GROBE: Thanks a lot.

Any other questions from here in Region III?

(No response.)

MR. GROVE: Bill Ruland, do you have anything else in headquarters?

MR. RULAND: Any questions? We have some questions from the media, but we will hold off until we have gotten around to everybody else.

MR. GROBE: We will get those in a minute, thanks.

I do appreciate your time, Gary, and I appreciate your coming over. 91 slides was impressive, but I think we got a lot of information. The one slide that there was a lot questions on was the monitoring going forward, and I think we are going to need to see a little bit more detail on that, and I'm not quite sure how we are going to do that, but I will get back

with you.

MR. LEIDICH: That's fine, we will work with you ourselves.

MR. GROBE: With that, Jim, do you have any comments for them?

MR. CALDWELL: Just to say thanks for coming to give us this briefing and bringing us up to speed on where you are on the safety culture. There is a lot of problems obviously that resulted in the shutdown, beginning of which was the cavity vessel head, but root cause involved technical issues, and the main one, the hard one, the one that is going to be difficult to close out -- the technical issues you can fix, and it's pretty clear, but the one that had both management and on down is putting production over safety was the -- is the real problem and also making sure that the information you are providing is complete and accurate. That is an issue that we still have to deal with.

But at Davis-Besse we talked -- you guys talk about safety culture and the safety

conscious work environment, and one thing you didn't mention is that it goes back to the fundamentals, I'm not sure that folks could actually identify safety issues. Whether they would bring it up or not is a different thing, it's actually understanding what safety issues are, and then being willing to bring them up. So you need to make sure that you understand that people can understand what the safety issues are.

And then you talked about the alignment, and making sure folks are aligned and have a common understanding and ownership of the issues going forward. You have meetings, discussions, but in the end it will be the actions, walking the walk that will determine whether or not the folks buy into this safety culture, and understanding that that is the direction that management is taking in the plants.

So those things -- Geoff brought up a good point earlier when he talked about your -- the assessment tool that you have. There are

a lot of opportunities going forward where you will make decisions that -- the decision you just made recently on the seven days, was it consecutive? It was broken up because of some of the problems that I heard. When I mean we looked at it from this side and determined that it was equivalent or better than, but the first discussions we had from your side was we didn't commit to seven consecutive days, and we discussed that you look at it from an engineering perspective to make sure it's at least equivalent or better, and that is the type of communication that not only do we want to hear and the public wants to hear, but your staff needs to hear that the decisions you are making are related to what's best for the safety of the plant. And so those -- so you have a number of opportunities.

This assessment tool, you have red issues, or issues that would appear to be showstoppers, those are -- you not only have to convince us in the public, you need to convince your staff that you thoroughly reviewed it and

understood it, and that it's not a safety issue going forward.

So there is a lot of opportunities you have to reinforce your standards and expectations, and they come in the guise of communications not only to us in the public, but to your staff as well. And those are all the management issues.

Scott touched on the operations issue, and in reality when it comes down to the operators, all the plants in this country that have been successful are successful because they have a strong ops organization that leads the plants, sets the standards, will not accept degraded conditions, and you can see for a couple of years the plant that engineering leads or maintenance leads, in a couple of years it will be okay, and then it will degrade, not because those people are doing anything wrong, but because they don't have the same insights that the operators have on what's acceptable to operate the plants, so it has to be op lead, and

like you said, in the middle of the night those are the folks that are going to be making the decisions. I know you are on your beeper, but they are still going to make the decisions. And we have the plants that in the middle of night that the operator makes bad decisions and those decisions resulted in the plants being shut down for an extended period of time. So you set the standards and expectations with your actions as well as you were words, but mainly your actions. And then operations has to reinforce that on a day-to-day, continuing basis.

Anyway, we appreciate your coming, and like I said, 90 slides is a lot to go through, but we will spend some more time trying to work through this. Thank you.

MR. GROBE: We are going to take just a couple of minutes to get reorganized here and then take questions from the public.

(Whereupon, a recess was had, after which the hearing was resumed as

follows:)

MR. GROBE: Okay. I think what we'd like to do is I'd like to start with questions from anybody here in the Region III office. If anybody has any questions, approach the microphone and we'd be glad to answer them. And then, Bill, we will move to headquarters, and then we will move to the phone line.

So is there anybody here, a member of the public that has a question or comments that they'd like to address to us?

(No response.)

MR. GROBE: It's a quiet group today. Okay.

Bill Ruland, is there anyone at headquarters that has questions?

(No response.)

MR. GROBE: We will go to the phone lines.

THE OPERATOR: Our first question comes from Ashar Kahn. You may ask your question.

MR. KAHN: Our first questions, I guess, after hearing very comprehensive dialogue

regarding the safety culture issue, can I just ask from N.R.C. or management who was there that -- do they believe that based on today's discussion and findings, whatever the findings are of the M.P. test that the management still believes they will be able to restart this plant in the fourth quarter of this year?

MR. GROBE: Mr. Kahn, this is your opportunity to ask the N.R.C. staff questions, and I can respond to your question. The schedule is not something we focus on with the N.R.C. What we focus on is safety, and I can tell you the plant is not ready to restart today, there is still a number of activities that have to occur before restart would be considered.

The steps that would be gone through include internal assessments and evaluations that the company will do within their organization, and then providing a final report to the N.R.C., followed by a meeting with the N.R.C. to discuss progress step by step, and eventually, if appropriate, a decision by the

N.R.C. that restart should occur.

We don't tie ourselves to a schedule, that will happen when it's appropriate and when the N.R.C. believes that the plant can be safely restarted and safely operated into the future.

MR. KAHN: But if I heard right, is there going to be another public meeting on the safety culture, I guess the management coming back with certain assessments and reviews?

MR. GROBE: We have public meetings all the time, usually several a month, and one of the discussion items we talked about was getting more detail from the company on the assessment process going forward. Some of the assessments are still in the developmental phase, and we have a number of questions in that area in addition to our safety culture assessment. Our inspection team is continuing its work, and when they complete their work, we will have a public dialogue regarding the inspection findings at that time.

So we --

MR. KAHN: If I can end up by saying, what does the N.R.C. staff feel where we are at at the present moment as far as whether things have progressed well and are things are going in the right direction as you see them as you have discussed today with what they presented and what you have seen and inspected over the last, you know, several months?

MR. GROBE: That's a very general question, it can only be answered with a very general answer, and that is that progress continues to be made.

MR. KAHN: I appreciate it.

THE OPERATOR: Our next question comes from Paul Patterson. You may ask your question.

MR. PATTERSON: Hi, can you hear me?

MR. GROBE: Yes, sir.

MR. PATTERSON: Just to sort of follow-up on the previous question, in terms of the issues, I mean, there were clearly some issues that both you and the company, the N.R.C. and the company felt that there needed to be improvement, but

prior to restart were there any specific issues that you guys identified that had to be rectified, or did you feel that the presentation, the 91 slides, which unfortunately we weren't able to see, gave you enough comfort to feel that they at least with the specific issues are ready to restart, if you follow me?

MR. GROBE: Hopefully you can gain access to an Internet connection, the slides are available on the N.R.C. web site.

MR. PATTERSON: Okay.

MR. GROBE: Specific to your question, there is a restart checklist that the N.R.C. issued, I think it was in the fall of 2002, it's been updated several times since then. That restart checklist includes specific items that need to be completed prior to restart and a number of areas first. Root cause assessments area; second is systems readiness; third, have programs readiness; fourth is the management and human resource performance and refocused a lot of attention in that area today.

The further area is operations readiness, and then the sixth and seventh areas are any licensing actions that are necessary for restart and completion, confirmatory action letter. So there is quite a few specific items that need to be completed before restart.

Currenty I believe there is 18 of 31 of those checklist items have been closed out formally, and actions are underway on most of the rest of them to evaluate licensing progress.

MR. PATERSON: So in terms of issues that you guys addressed today, that doesn't constitute, I guess, things being checked off, there is still some work to be done?

MR. GROBE: That is correct.

MR. PATTERSON: And I'm wondering if you can give us an idea as to whether we will get a better picture on that in terms of that portion of the checklist being resolved, the safety culture issues?

MR. GROBE: You are correct that part of the checklist has not yet been resolved. There

was several items in that area, one was whether or not their evaluations were adequate, that that's been closed out and adequately resolved.

The second item was whether or not the plans to improve safety culture were sufficient. It appears to be sufficient, and that also has been addressed and closed out. The third item is the effectiveness of those activities, and that item is still open, the inspection is ongoing, and as soon as the inspection is completed, we will report the results of that inspection publicly.

MR. PATTERSON: Thank you, very much.

THE OPERATOR: Once again, if anyone would like to ask a question from the audio portion, please touch Star 1 on your telephone. One moment.

The next question comes from Paul Branch. You may ask your question.

MR. BRANCH: Good afternoon, Paul Branch. I think most of you know who I am and you know I have looked at all the slides today, and I think

that Davis-Besse is right on, they have good plans. But what I also looked at is what are the results of these plans? If we look at the -- both the Davis-Besse and the N.R.C. data, this year there are seven allegations of harassment, discrimination and intimidation as of the end of August. This is the highest in the country. There are still 23 open allegations, and again No. 1 in the country. There are 22 allegations total of just technical, general allegations, and this is the highest in the country.

I think the most bothersome thing was the Question No. 35 that appeared on Slide No. 53, and the question was -- which was to me the one objective question, and the question or the statement was, "I have been subjected to harassment, intimidation, retaliation or discrimination in the last six months, and I'm just looking at the FENOC, the Davis-Besse employees, five percent or 34 employees in the last six months perceived they have been the subject of retaliation. You know, in my many

years, that is a very high number, that is five percent, 1 out of 20. And, again, those are just statements. I'd like to hear any comments on that, but I'd also like to ask the question about the completion of the safety conscious work environment or safety culture assessment team that's been ongoing since last June. When is that expected to be completed?

And the second question is, who is in the Employee Concern Program at Davis-Besse that didn't come across or make -- I missed that, so I will wait and relisten to the response.

MR. GROBE: Thanks, Paul. That is several questions, let's see if I can capture them. First, the inspection into the area of safety culture and safety conscious work environment will be completed when the company finishes the work that they need to finish, and we need to assess and we have an opportunity to assess that, so that will be done when it's done.

The second question you asked I think concerned several questions on the survey

that was done regarding safety conscious work environment earlier this year. Your questions were identical to questions that the N.R.C. staff asked -- well, first insurance asked them questions regarding what the meeting was, of those results, they shared some of that today and indicated that they were planning another survey before restart, which will have clarifying questions in those areas to ensure that the data that is collected is as meaningful as need be. So we will get additional input on that.

I think I have answered your questions.

MR. BRANCH: Well, the other question was, I guess I'm not clear who is leading the employee concerns program out at Davis-Besse.

MR. GROBE: I don't have specific names, it's under the vice-president of oversight, Fred von Ahn at the corporate office.

MR. BRANCH: Okay. Thank you.

THE OPERATOR: At this time have I no further questions.

Thank you, sir.

MR. GROBE: Bill Ruland, we have you guys back on the line.

MR. RULAND: We have questions from the media here, he is repositioning himself.

MR. HORNET: Dan Hornet from McGraw-Mill Publications.

Could you clarify a bit on the schedule of the meetings that need to take place before restart, because you mentioned another safety culture meeting before Mode 4, and it wasn't clear to me if that was part of this overall assessment once FENOC has submitted its report, or if it's a separate meeting and how that worked, because I understand it's also supposed to be a meeting on the HPI pumps, I believe, so can you sort of lay that out and give us a clear idea?

MR. GROBE: I can tell you what I know, Dan, and I will tell what you I don't know. The answer to your question regarding additional information on safety culture, I'm not sure when

that will occur, whether it will be one of our routine monthly meetings or a separate focused meeting. But as of right now, next Tuesday, which is October 7th, we have a meeting at 2:00 o'clock in the afternoon and another one at 7:00 in the evening concerning -- this is our routine monthly meeting or set of meetings, and a significant portion of the agenda will be focused on the results of the normal operating pressure test and the evolutions that went into conducting that test.

Then the following day we have a meeting to discuss two topics, and that will concern the results of the inspection of the corrective action program and the systems health readiness of the systems to operate. Our November meeting, November 4th is the next set of routine public monthly meetings, and those will be, I believe, at the high school in Oak Harbor.

The meetings on Tuesday next week are at Camp Perry in Port Clinton. In addition, there is a meeting that is scheduled -- going to

be scheduled in headquarters, I don't believe we have a final date, it's around the 20th of October, and the subject of that meeting is going to be the high pressure injection pump's design modification and the results of the testing that is being done on those pumps in Alabama.

We also had a tentative date for routine monthly meeting in December, so as far as when we are going to discuss safety culture topics, I'm not sure if that will be a separate focused meeting or one of the monthly meetings.

Of course, in addition, that confirmatory action letter contained, as a condition, that the company would meet with N.R.C. prior to restart, and First Energy has, in response to that, agreed to provide a comprehensive restart report prior to that meeting, and that meeting is not currently scheduled or contemplated. But prior to the meeting, we will receive a comprehensive report, and then conduct a meeting. A decision will not be made at that meeting, whatever occurs, but

that will be a final bit of data that the N.R.C. will be considering, along with all of the other inspection results that we have been collecting over a lengthy period of time. The panel will consider all of that input and then decide whether it needs additional information or whether it's ready to make a recommendation to the Regional Administrator, Jim Caldwell, if the plant is ready to restart. At this point Jim will consult the panel and consult with Jim Dwyer, the director of reactor safety in headquarters, as well as Sam Collins, the deputy executive director for reactors, and he would make a decision on restart.

So that last bit of information I can share with you is the date or schedule for that is not contemplated yet.

MR. HORNET: I did go to a safety culture meeting before Mode 4. Is there some formal approval coming out of that meeting that FENOC is required to have before they can enter Mode 4 regarding their safety culture other than the

overall approval that is pursuant to the confirmatory action letter that you mentioned?

MR. GROBE: I think the meeting is an internal FENOC meeting, it's not a meeting with the N.R.C., it's an internal meeting where First Energy evaluates its -- their readiness in three areas, one is safety culture organizational readiness, the second one is equipment readiness, and the third is programmatic readiness. Those are kind of broad concepts, but that is the purpose of that meeting. They will conduct meetings internal to their organization prior to Mode 4, and then again prior to Mode 2.

In addition, they had internal, within their organization, a series of approvals that they need to go through, and those include their external oversight restart oversight panel, the corporate Nuclear Review Board, that is a restart oversight panel that is comprised of individuals from around the industry, the Corporate Review Board is an internal FENOC entity that is independent of the site, as well

as the Senior Management Team in the FENOC organization both on-site at Davis-Besse and off-site at the corporate office.

So they have a number of reviews and approvals that they do go through before they would come to the N.R.C. for a restart recommendation.

MR. HORNET: Okay. Will that be continuing, because I know that at least -- continue in existence for quite a while after restart, so will there be -- continue to be safety culture meetings at least these same meetings after restart?

MR. GROBE: The company described in some broad context what it plans to do to assess safety culture after restart, and they will be meeting regarding operational performance and organizational performance, and as appropriate those meetings will include dialogues on safety culture, but the frequency of those meetings hasn't been determined yet, but following restart I anticipate retaining fairly frequent meetings

to share with the public operational performance, and as you indicated, the panel will remain in existence until the point in time that the panel believes Davis-Besse performance warrants return to the routine oversight process that the agency uses for normally operating plants.

MR. HORNET: Okay. Thank you on that line.

A second line, there was several points that FENOC mentioned in the Sonja Haber report. Can I ask you to say a little bit about how you are using it at this point, because using it as a yardstick against which to measure FENOC on how are you using it, I guess are the FENOC representatives still --

MR. GROBE: They are still here, but you are asking me questions, and I can answer the question from the N.R.C. context. The report is being used for a number of purposes, one is to get a benchmark on safety culture in the plant, and the second is to gain insights on evaluation techniques and alignment between the internal and external evaluation tool that is used as the Dr.

Haber tool, as well as the various internal FENOC tools that they are using, and the third was to evaluate the adequacy of their root cause assessments and their corrective actions going forward. And so that the independent assessment report is being used as well as their internal assessment in a number ways.

MR. HORNET: Is there ongoing contact with her or her organization to get her feedback as to how well they are addressing the issues that she raised in the report?

MR. GROBE: I don't know if First Energy is having any contact with her. Our inspection team had quite a bit of interface with Dr. Haber's team in evaluating the assessment that was conducted, so I can't answer your question regarding First Energy.

Is there anybody else there that has any questions?

MR. RULAND: No, there is no one else.

MR. GROBE: If you have anymore questions, let's get them quickly and see if there is

anybody else on the phone lines before we adjourn.

MR. RULAND: I think that should do it.

MR. GROBE: Okay. Anybody else here in Region III?

(No response.)

MR. GROBE: Let's go to the phone lines one more time.

THE OPERATOR: Once again if would you like to ask a question, please press Star 1 on your touch-tone telephone. Sir, I have no questions. Thank you.

MR. GROBE: Okay. Thank you very much. With that we stand adjourned.

(Which were all the proceedings had and testimony taken in the above-entitled matter at the time and place aforesaid.)

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

I, ELLEN E. PICCONY, a Notary Public duly qualified and commissioned for the State of Illinois, County of Kane, do hereby certify that subject to the usual terms and conditions of County Court Reporters, Inc., reported in shorthand the proceedings had and testimony taken at the hearing of the above-entitled cause, and that the foregoing transcript is a true, correct and complete report of the entire testimony so taken at the time and place hereinabove set forth.

_____
Notary Public

My Commission Expires
October 15, 2003.